2006

Uniform Medical Plan
Preferred Provider Organization (PPO)

Certificate of Coverage for Retirees

Uniform Medical Plan
Your health. Your plan. Your choice.

Self-Insured by the State of Washington
Effective January 1, 2006

Printed under the direction of the Washington State Health Care Authority Public Employees Benefits Board

HCA 54-560 (10/05)

Directory

If you have questions about…	Contact…	
Customer Service	**1-800-352-3968 or 425-686-1350 (Seattle area)** **Monday-Friday, 8 a.m. to 6 p.m.**	
Appeals, First Level; Correspondence, Complaints, Preauthorization, Medical Review	Uniform Medical Plan PPO P.O. Box 34578 Seattle, WA 98124-1578	Toll-free: 1-800-352-3968 Local (Seattle area): 425-686-1350 Fax: 425-670-3197
Benefit Information, Certificates of Coverage, I.D. Cards, Claim Forms, Claims Status	Uniform Medical Plan P.O. Box 34850 Seattle, WA 98124-1850	**www.ump.hca.wa.gov** Toll-free: 1-800-352-3968 Local (Seattle area): 425-686-1350
Finding a Network Provider	For services in: **Washington and Idaho border counties** of Bonner, Kootenai, Latah, and Nez Perce: 1-800-352-3968 or 425-686-1350 (Seattle area) or **www.ump.hca.wa.gov** **Other U.S. locations (Beech Street):** 1-800-432-1776 or **www.beechstreet.com**	
Prescription Drugs **Member Services, Network Pharmacies, Preferred Drugs Questions, Complaints**	Express Scripts, Inc. 1-866-576-3862 Available 24 hours a day, 7 days a week	**www.express-scripts.com**
First-Level Appeals, Correspondence	Express Scripts, Inc. Attn: Pharmacy Appeals: WA5 Mail Route BLO390 6625 West 78th Street Bloomington, MN 55439	Fax: 1-877-852-4070 Enrollee phone: 1-866-576-3862 Provider phone: 1-800-417-8164
Drug Coverage Management and Preauthorization	1-800-417-8164 Provider to call on enrollee's behalf	
Mail-Service Pharmacy ***First prescription, order by mail:*** **Note:** Use Web site only for refills.	Express Scripts, Inc. P.O. Box 52166 Phoenix, AZ 85072-9886	
Refills:	Express Scripts, Inc. 1-866-576-3862	**www.express-scripts.com**
Claims from Non-Network Pharmacies	Express Scripts, Inc. WA5A P.O. Box 390873 Bloomington, MN 55439-0873	
Case Management See page 20 for more information.	1-888-759-4855	
Eligibility and Enrollment	PEBB Benefit Services 1-800-200-1004 or 360-412-4200 Fax: 360-923-2602 Monday-Friday, 8 a.m. to 5 p.m.	**www.pebb.hca.wa.gov**
Preventive Care Guidelines	**www.ahcpr.gov/clinic/gcpspu.htm** **www.cdc.gov/nip/publications/ACIP-list.htm**	
Tobacco Cessation	*Free & Clear* 1-800-292-2336 Monday-Friday, 8 a.m. to 6 p.m.	**www.freeclear.com**
Address Changes	Health Care Authority P.O. Box 42684 Olympia, WA 98504-2684	
Washington Hotline Numbers	Alcohol and Substance Abuse 1-800-562-1240 Domestic Violence 1-800-562-6025 Emergency Contraception 1-888-668-2528 Family Planning 1-800-770-4334 HIV-AIDS (national) 1-800-342-2437 Poison Control 1-800-732-6985	

To Learn More About... See Page...

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To obtain this booklet in another format (such as Braille or audio), call our Americans with Disabilities Act (ADA) Coordinator at 360-923-2805. TTY users (deaf, hard of hearing, or speech impaired), call 360-923-2701 or toll-free 1-888-923-5622.

To Learn More About... See Page...

How the UMP PPO Works (continued)

To Learn More About... See Page...

This booklet explains benefit provisions specific to UMP PPO and is the certificate of coverage for UMP PPO enrollees. (This certificate of coverage supersedes previous certificates.)

If provisions in this booklet are inconsistent with any federal or state statute or rule, the language of the statute or rule will govern.

This booklet was compiled by the Washington State Health Care Authority/Uniform Medical Plan, PO Box 91118, Seattle, WA 98111-9218. If you have any questions about these provisions, please contact UMP (see the Directory).

Highlights

Welcome to the Uniform Medical Plan Preferred Provider Organization (UMP PPO)! UMP PPO is a self-insured plan designed by the Public Employees Benefits Board (PEBB) and administered by the Washington State Health Care Authority (HCA). Your coverage through UMP PPO gives you access to one of the largest provider networks in Washington State, as well as care from out-of-state networks in most other parts of the country for retirees not enrolled in Medicare.

This plan is designed to keep you and your family healthy in addition to providing benefits in case of illness or injury. As you know, your health care coverage can be one of your most important benefits. Please review this booklet carefully so that you can take advantage of all this plan has to offer. In addition, you can visit the UMP Web site at **www.ump.hca.wa.gov** to access the following:

- Online accounts, where you can look at your medical and pharmacy claims information through secure Web sites.
- Secure e-mail to submit questions to Customer Service (through your online account).
- Benefits information.
- UMP's preferred drug list.
- Provider and pharmacy network directories.
- UMP publications and forms.
- Links to health resources and Medicare information.
- Explanations of complaints and appeals processes.
- Frequently asked questions.

UMP PPO Features

Here are a few important plan features:

- When covered by UMP PPO, you can choose to see network, out-of-network, or non-network providers. These different options are described on pages 14-15, along with the coverage differences.
- In most cases, UMP PPO allows you to self-refer for services from network, out-of-network, and non-network providers belonging to any approved provider type (see list beginning on page 15).
- Worldwide coverage for nonemergency and emergency care is a definite plus when you travel. See "Coverage Outside Washington State" on pages 17-18 for specific information.
- Although you can select any approved provider type, network providers offer several advantages:
  - Higher level of coverage.
  - No claim forms for you to fill out.
  - Your enrollee coinsurance applies to your annual medical/surgical out-of-pocket limit.
  - Preventive care, preauthorized hospice services, and tobacco cessation services through *Free & Clear* are covered at 100% of allowed charges.
  - You're not responsible for differences between the provider's billed charge and the UMP allowed charge.
- Because the UMP PPO network includes such a large number of physicians and other health care professionals, it's likely your current provider is already a network provider.
- All care must be medically necessary (as defined on pages 75-76) to be covered.
- Enrolling in UMP PPO also gives you access to network pharmacies nationwide, where you can purchase retail prescription drugs at discounted rates—with no claim forms to worry about. You may also order prescriptions through our mail-service pharmacy. See pages 20-24 and 36-38 for details on your prescription drug benefits.
- Preventive care, routine vision exams and hardware, tobacco cessation services through *Free & Clear* and required second opinions are not subject to the annual medical/surgical deductible.
- For Medicare retirees, claims for outpatient services in Alaska, Arizona, Colorado, Hawaii, Iowa, Nevada, North Dakota, Oregon, South

Dakota, Washington, and Wyoming are submitted electronically to UMP.

How to Use the Plan

- Review the UMP PPO's online provider and pharmacy directories at **www.ump.hca.wa.gov**, or call UMP Customer Service at 1-800-352-3968 or 425-686-1350 in the Seattle area to request these directories.
- Choose a UMP PPO network provider or UMP network pharmacy. Provider can refer to a person (a doctor or other health care professional) or a facility (such as a hospital, clinic, etc.). Since network changes occur daily, when calling for an appointment ask if your provider is a UMP PPO network provider. You may also call UMP to confirm your provider's status. Remember that UMP PPO network providers are covered at a higher benefit level and give you other advantages as well. Network pharmacies offer not only a discounted price but also cap the amount you pay for certain retail prescription drugs. Network providers and network pharmacies offer you financial protection, because you cannot be billed for the difference between their billed charge and the UMP allowed charge for covered services.
- Identify yourself as a UMP PPO enrollee when you make an appointment with a network provider.
- Present your UMP PPO I.D. card when you receive health care services or have a prescription filled. When UMP PPO is the primary payer (see definition on page 78), the network provider or network pharmacy will submit the claim for you.
- Where there is no access to network providers, receive out-of-network benefits anywhere in the world! Please note that out-of-network providers can bill you for the difference between the UMP allowed charge and the provider's billed charge, in addition to UMP PPO cost-sharing requirements (see pages 5-6).
- You may choose to use non-network providers; however, if you do so, you will pay more, and none of your out-of-pocket expenses will apply to your annual out-of-pocket limit. In addition, you may be responsible for submitting your own claims to UMP. Non-network providers can bill you for the difference between their billed charge and the UMP allowed charge, in addition to the cost-sharing requirements described on pages 5-6. Pharmacies not contracted with UMP will usually cost you more as well; see pages 20-23 for more information.

If you are a Medicare-enrolled retiree, network providers are available only in Washington and the Idaho counties of Bonner, Kootenai, Latah, and Nez Perce. You also receive network-level benefits when you use providers who accept Medicare assignment, anywhere in the U.S.

- Remember that some services and prescription drugs require medical review/preauthorization (see pages 18-19 and 24 for details). This discourages unnecessary care, saves money for you and UMP PPO, and helps ensure the treatment and drugs you receive are necessary and appropriate. Although you're responsible for obtaining medical review/preauthorization and prescription drug review, your network provider or pharmacy may assist you with this process.

Your Rights and Responsibilities as a UMP PPO Enrollee

To ensure UMP PPO offers the best possible medical care, we must work together with you and your providers as partners. To achieve this goal, you must first know your rights and responsibilities.

As a UMP PPO enrollee, you have the right to:

- Be treated with respect.
- Be informed by your providers or UMP about all appropriate or medically necessary treatment options for your condition, regardless of cost or benefit coverage.

- Have information about:
  - How new technology is evaluated for inclusion as a covered benefit.
  - How providers are reimbursed by UMP PPO.
  - Preauthorization and review requirements.
  - Providers you select and their qualifications.
  - UMP and our network of providers.
  - Your covered expenses, exclusions, and maximums/limits.
- Keep your medical records and personal information confidential.
- Obtain a second opinion regarding your provider's care recommendations.
- Make decisions in consultation with your providers about your health care.
- Make recommendations about enrollee rights and responsibilities.
- Have a translator's assistance, if required, when calling UMP.
- Receive:
  - All medically necessary covered services and supplies described in your *Certificate of Coverage*, subject to the maximums/limits, exclusions, deductibles, and enrollee coinsurance/copays.
  - Clear information from your provider about illness or treatment before services and supplies are provided.
  - Courteous, prompt answers from UMP.
  - Timely, proper medical care without discrimination of any kind—regardless of health status or condition, sex, ethnicity, race, marital status, or religion.
  - Written explanation from UMP regarding any request to refund an overpayment.
- Voice complaints or initiate appeals about UMP PPO services, decisions, or the care you receive.

As a UMP PPO enrollee, you have the responsibility to:

- Complete and return the annual coordination of benefits questionnaire you receive from UMP in a timely manner to prevent delay in claims payment.
- Enroll in Medicare Parts A and B as soon as you are entitled.
- Comply with requests for information by the date given.
- Follow your providers' instructions about your health care.
- Give your providers complete information about your health to get the best possible care.
- Keep your providers' phone numbers handy and know how to make or cancel an appointment as well as how to reach your providers after hours.
- Know how to access emergency care.
- Not engage in fraud or abuse in dealing with UMP or your providers.
- Participate with your providers in making decisions about your health care.
- Pay your copayments, coinsurance, or deductibles promptly.
- Refund promptly any overpayment made to you or for you.
- Report to UMP any outside sources of health care coverage or payment as well as any changes in your dependents or in your address.
- Show the same respect to your providers and UMP as you expect from them.
- Understand your UMP PPO benefits, including what's covered, preauthorization and review requirements, and other information described in this *Certificate of Coverage*.
- Use UMP PPO network providers when available to help ensure quality care at the lowest cost.

Information Available to You

We support the goal of giving you and your family the detailed information you need to make the best possible health care decisions. The following information can be found in this *Certificate of Coverage*:

- List of covered expenses (see pages 25-45).
- Benefit exclusions, reductions, and maximums/limits (see pages 46-49).
- Clear explanation of complaint and appeal procedures (see pages 53-57).
- Preventive health care benefits that are covered (see pages 38-43).
- Definition of terms (see pages 71-79).

The following information is available on the UMP Web site at **www.ump.hca.wa.gov**, or by calling UMP Customer Service at 1-800-352-3968.

- Description and justification for provider compensation programs, including any incentives or penalties intended to encourage providers to withhold services.
- Documents and other materials referred to in PEBB open enrollment materials or this *Certificate of Coverage*.
- General reimbursement or payment arrangements between UMP PPO and network providers.
- How you can be involved in decisions about benefits.
- List of network providers, including both primary care providers and specialists.
- Notice of privacy practices (includes UMP policy for protecting the confidentiality of health information; see "Confidentiality of Your Health Information" on this page).
- Preferred drug list, including policies regarding drug coverage and how drugs are added to or removed from the list.
- Procedures to follow for consulting with providers.
- Process for preauthorization/review.
- Accreditation information, including measures used to report health plan performance such as consumer satisfaction survey results or Health Plan Employer Data and Information Set (HEDIS) measures.
- Information on UMP PPO's disease management programs.
- When UMP PPO may retrospectively deny coverage for preauthorized care.

You may call UMP Customer Service for an annual accounting of all payments made by UMP PPO that have been counted against any payment limits, day limits, visit limits, or other limits on your coverage.

UMP does not prevent or discourage providers from informing you of the care you require, including various treatment options and whether, in the provider's view, that care is consistent with UMP PPO's coverage criteria. You may, at any time, obtain health care outside of UMP PPO coverage for any reason; however, you must pay for those services and supplies. In addition, UMP does not prevent or discourage you from discussing the merits of different health care insurers with your provider.

Confidentiality of Your Health Information

UMP follows our *Notice of Privacy Practices*, available online at **www.ump.hca.wa.gov/members/planinfo/privacypractices.shtml** or by calling Customer Service at 1-800-352-3968. Enrollee health information will be disclosed only as described in that Notice or as required or permitted by law or court order.

Release of Information

You may be required to give UMP or the Health Care Authority information necessary to determine eligibility, administer benefits, or process claims. This could include medical and other records. Coverage could be denied if you don't provide the information when requested.

Your Cost-Sharing Requirements

Medicare-entitled retirees: Be sure to read "If You Have Other Medical Coverage" starting on page 58.

Annual Medical/Surgical Deductible

A deductible is a dollar amount you must pay before UMP PPO will pay most benefits. Medical/surgical services are subject to their own annual medical/surgical deductible, and do not apply to the annual prescription drug deductible. Your annual medical/surgical deductible is $200 per person and is calculated from January 1 to December 31, even if you're enrolled for only part of the year. For example, if you enroll in July, you would still have to pay the entire annual medical/surgical deductible for that year before the plan would reimburse for medical/surgical benefits, then would have to pay a new medical/surgical deductible beginning in January next year.

For families of three or more covered persons, the maximum annual medical/surgical deductible payable by all family members combined under one subscriber's account is $600. When a family's total annual medical/surgical deductible reaches this amount, no further medical/surgical deductible will be required for any family member during that calendar year.

Please note: Charges applied to your annual deductible also count toward any applicable benefit maximum or limit. See definition of "Limited Benefit" on page 75 for more information.

Benefits Not Subject to the Annual Medical/Surgical Deductible

The following services are exempt from the annual medical/surgical deductible—they will be paid according to their own reimbursement schedules, even if the annual medical/surgical deductible has not been met:

- Preventive care benefits listed on pages 38-43.
- Required second opinions.
- Routine eye exams and vision hardware.
- Services received under the *Free & Clear* tobacco cessation program.

Please note that only the UMP allowed charge (see definition on page 71) is applied to either the deductible or the out-of-pocket limit. Charges exceeding the UMP allowed charge are not counted.

Annual Prescription Drug Deductible

Prescription drugs purchased through retail or mail-order pharmacies are subject to their own annual prescription drug deductible, and do not apply to the annual medical/surgical deductible.

Your annual prescription drug deductible is $100 per person, calculated for prescriptions filled from January 1 to December 31. For families of three or more covered persons, the maximum annual prescription drug deductible payable by all members of a family combined under one subscriber's account is $300. Like the annual medical/surgical deductible, you must meet your full annual prescription drug deductible even if you enroll near the end of the year.

Coinsurance

Coinsurance is the percentage of allowed charges that UMP PPO pays for medically necessary covered services; enrollee coinsurance is the percentage you're required to pay when UMP PPO pays less than 100%. See the "Summary of Benefits" charts on pages 7-13 for coinsurance levels.

Copayments

A copayment is a dollar amount you pay when receiving specific services, treatments, or supplies, such as an inpatient hospitalization in a network facility, emergency room care, or a prescription filled through our mail-service pharmacy. See the "Summary of Benefits" charts on pages 7-13 for specific copayment requirements.

Annual Medical/Surgical Out-of-Pocket Limit

This out-of-pocket limit refers to the maximum total amount that you may be required to pay for most enrollee coinsurance and copayments each calendar year. Once your eligible enrollee coinsurance and copayment costs reach $1,500 per person or $3,000 per family (all family members combined under one subscriber's account), most medical/surgical claims for covered services from UMP PPO network providers or out-of-network providers (see page 77 for definition) are paid at 100% of allowed charges for the remainder of the calendar year.

After you have reached your annual medical/surgical out-of-pocket limit, you will still be responsible for the difference between your provider's billed charge and the UMP allowed charge for out-of-network services.

The following costs are not counted towards your annual medical/surgical out-of-pocket limit:

- Annual medical/surgical and prescription drug deductibles.
- Benefit reductions for failure to comply with medical review/preauthorization requirements.
- Charges beyond benefit maximums, limits, and allowed charges.
- Charges for expenses not covered.
- Copayments for emergency room care.
- Enrollee coinsurance/copayments for prescriptions filled at retail and mail-order pharmacies.
- Enrollee coinsurance/copayments for services from non-network providers.

Services provided by non-network providers are covered at 60% of allowed charges regardless of whether you have satisfied your out-of-pocket limit. In many cases, a provider's billed charge is higher than UMP's allowed charge. Your financial responsibility when using non-network providers is the combination of your 40% enrollee coinsurance plus the difference between billed and allowed charges.

Maximum Plan Payment

The total UMP PPO will pay for all benefits is limited to a lifetime maximum of $2,000,000 per enrollee. Up to $10,000 of the lifetime maximum is restored automatically each January 1 for benefits paid by UMP PPO during the prior calendar year. Some services are also subject to specific calendar year or other benefit limits, as detailed in the "Summary of Benefits" starting on page 7.

Summary of Benefits

This section summarizes your UMP PPO benefits. UMP PPO covers only medically necessary services and supplies, as defined on pages 75-76. Please refer to "Covered Expenses" as well as "Expenses Not Covered, Exclusions, and Limitations" for more details.

Please note that UMP PPO has no waiting period for coverage of pre-existing health conditions.

For any UMP PPO benefit, once you have met the cost-sharing requirements, the plan pays at the levels shown on the following summary charts, subject to any benefit maximums or limits indicated. The percentage paid by the plan refers to percentage of the allowed charge only. The remaining amount of the allowed charge is your enrollee coinsurance (defined on page 73).

The fact that a provider orders a test or prescribes a treatment does not necessarily mean that it is covered by UMP. Please consult this Certificate of Coverage*, or call UMP Customer Service if you have questions about whether a service or supply is covered.*

Only the allowed charge is covered—the maximum payment the plan allows for a specific service or supply (see definition on page 71). In many cases, the UMP's allowed charge is less than the provider's billed charge for the service. If you use non-network or out-of-network providers, you will also be responsible for the difference between the provider's billed charge and the UMP allowed charge for the particular service (that is, in addition to UMP PPO cost-sharing requirements). Network providers have agreed to accept the UMP allowed charge as payment in full; out-of-network and non-network providers have not. See pages 14-15 for more information on your provider options.

In most circumstances, UMP PPO follows Medicare coverage guidelines, payment policies, and billing requirements.

Some services also have specific limits, as shown in the summary charts.

If you also have Medicare coverage, see "UMP Provisions for Retirees on Medicare" on page 59.

The following sections describe your UMP PPO benefits along with other details you'll need to use the plan effectively. If you have questions, see the Directory (inside the front cover) for contact information.

For more information on what isn't covered and benefit limits, see "Summary of Benefits" and "Expenses Not Covered, Exclusions, and Limitations."

Summary of Benefits

All covered benefits are subject to the annual medical/surgical deductible unless otherwise noted. **Percentages shown in chart apply to the UMP allowed charge, which is the amount agreed upon by UMP network providers.**

Benefits	Plan payment for network providers	Plan payment for non-network providers**	Preauthorization required?	See page***
Acupuncture 16 treatments max/year	90%	60%	No	25, 46
Ambulance				25-26, 46
Air and ground	80%	80%	No	
Biofeedback (if for mental health diagnosis, see "Mental Health Treatment" on page 32)	90%	60%	No	26, 32
Blood and Blood Derivatives	90%	60%	Only for stem cell harvesting for transplant purposes	26
Bone, Eye, and Skin Bank Services	90%	60%	No	26
Cardiac and Pulmonary Rehabilitation	90%	60%	Yes	19, 26
Chemical Dependency Treatment $13,000 maximum plan payment per consecutive 24 calendar month period for inpatient and outpatient treatment combined ($13,000 limit excludes detox if you haven't been admitted to a chemical dependency program when receiving those services)				26, 46, 72
• **Inpatient**	100% after $200 copay/day; $600 max copay/person/year	60%	No	
• **Outpatient**	90%	60%	No	
Diabetes Education See page 27.	90%	60%	No	27, 46
Diagnostic Test, Laboratory, and X-Rays (outpatient)	90%	60%	Certain services	28, 48
Dialysis	90%	60%	No	28
Durable Medical Equipment, Supplies, and Prostheses ***Note:*** For a wig or hairpiece to replace hair lost due to radiation or chemotherapy, $100 lifetime max.	90%	60%	Yes, for rentals over 3 months and purchases over $1,000	18-19, 29, 47, 73

*Not subject to the annual medical/surgical deductible.

** Your cost-share for these services does not count towards the annual medical/surgical out-of-pocket limit, and is exempt from that limit. See exception for out-of-network care on page 15.

*** Several exclusions listed in "Expenses Not Covered, Exclusions, and Limitations," may apply to all benefits. Please review the "Expenses Not Covered, Exclusions, and Limitations" section carefully.

All covered benefits are subject to the annual medical/surgical deductible unless otherwise noted. **Percentages shown in chart apply to the UMP allowed charge, which is the amount agreed upon by UMP network providers.**

Benefits	Plan payment for network providers	Plan payment for non-network providers**	Preauthorization required?	See page***
Emergency Room (ER) ER copay waived if admitted directly from ER; copay does not count toward the annual medical/surgical deductible or medical/surgical out-of-pocket limit.	90% after $75** copay/visit	80% after $75** copay/visit	No	29, 75
Hearing Care $400 max/36 months applies to routine hearing exam, hearing aid, and rental/repair combined	90%	60%	No	29, 47
Home Health Care	90%	60%	Yes	19, 30, 47, 74
Hospice Care Six months maximum benefit				19, 30, 47, 74
• **Inpatient**				
When preauthorized	100%	60%	Yes	
When NOT preauthorized	90%	60%	No	
• **Respite care** ($5,000 lifetime max)	100%	60%	Yes	
Hospital Services				
• **Inpatient**				30, 48
Facility services *May not include doctors' and other professional services*	100% after $200 copay/day; $600 max copay/person/year	60%	No; see "Physical, Occupational, and Speech Therapy" for exceptions.	
Professional services *See pages 30-31 for important information*	90%	60%	No	
• **Outpatient**	90%	60%	No	31
Mammograms				
• **Screening mammograms*** (beginning at age 40, every one or two years)	100%	60%	No	28, 43
• **Diagnostic mammograms**	90%	60%	No	28

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*Not subject to the annual medical/surgical deductible.

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*** Several exclusions listed in "Expenses Not Covered, Exclusions, and Limitations," may apply to all benefits. Please review the "Expenses Not Covered, Exclusions, and Limitations" section carefully.

Summary of Benefits, continued

All covered benefits are subject to the annual medical/surgical deductible unless otherwise noted. **Percentages shown in chart apply to the UMP allowed charge, which is the amount agreed upon by UMP network providers.**

Benefits	Plan payment for network providers	Plan payment for non-network providers**	Preauthorization required?	See page***
Massage Therapy 16 visits max/year	90%	Not applicable; **massage therapists must be network providers to be covered.**	Only for services exceeding one hour per session. Treatment plan required.	19, 31, 48
Mastectomy and Related Services	90%	60%	No	31
Mental Health Treatment				19, 32, 48, 49
• **Inpatient:** 10 days max/year	100% after $200 copay/day; $600 max copay/person/year	60%	Only for partial hospitalization services	
• **Outpatient:** 20 visits max/year	90%	60%	No	
Naturopathic Physician Services	90%	60%	No	33, 46, 47
Neurodevelopmental Therapy (Ages 6 years and under)				33, 48
• **Inpatient:** 60 days max/year	100% after $200 copay/day; $600 max copay/person/year	60%	No	
• **Outpatient:** 60 visits max/year for all therapies combined	90%	60%	No, but treatment plan required	
Obstetric and Newborn Care				33
• **Inpatient**				
Facility charges	100% after $200 copay/day; $600 max copay/person/year (Routine newborn nursery care is not subject to copay.)	60%	No	
Professional services	90%	60%	No	
• **Outpatient**	90%	60%	No	
Office, Clinic, and Hospital Visits	90%	60%	No	34, 46, 48

*Not subject to the annual medical/surgical deductible.

** Your cost-share for these services does not count towards the annual medical/surgical out-of-pocket limit, and is exempt from that limit. See exception for out-of-network care on page 15.

*** Several exclusions listed in "Expenses Not Covered, Exclusions, and Limitations," may apply to all benefits. Please review the "Expenses Not Covered, Exclusions, and Limitations" section carefully.

All covered benefits are subject to the annual medical/surgical deductible unless otherwise noted. **Percentages shown in chart apply to the UMP allowed charge, which is the amount agreed upon by UMP network providers.**

Benefits	Plan payment for network providers	Plan payment for non-network providers**	Preauthorization required?	See page***
Organ Transplants				19,34, 48
• **Inpatient**				
Facility charges	100% after $200 copay/day; $600 max copay/person/year	60%	Yes	
Professional services	90%	60%	Yes	
• **Outpatient**				
Donor search (bone marrow, stem cell, umbilical cord) is limited to 15 searches per transplant	90%	60%	Yes	
Out-of-Network Care Includes care obtained in locations without access to network providers, including the Idaho counties of Bonner, Kootenai, Latah, and Nez Perce	Not applicable	80%	Varies by service/supply	15, 77
Outpatient/Day Surgery, Ambulatory Surgical Center (ASC)	90%	60%	No	35, 49
Phenylkentonuria (PKU) Supplements	90%	60%	No	35
Physical, Occupational, and Speech Therapy				19, 35
• **Inpatient:** 60 days max/year for all therapies combined	100% after $200 copay/day; $600 max copay/person/year	60%	Yes	
• **Outpatient:** 60 visits max/year for all therapies combined	90%	60%	No, but treatment plan required	

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*Not subject to the annual medical/surgical deductible.

** Your cost-share for these services does not count towards the annual medical/surgical out-of-pocket limit, and is exempt from that limit. See exception for out-of-network care on page 15.

*** Several exclusions listed in "Expenses Not Covered, Exclusions, and Limitations," may apply to all benefits. Please review the "Expenses Not Covered, Exclusions, and Limitations" section carefully.

Summary of Benefits, continued

All covered benefits are subject to the annual medical/surgical deductible unless otherwise noted. **Percentages shown in chart apply to the UMP allowed charge, which is the amount agreed upon by UMP network providers.**

Benefits	Plan payment for network providers	Plan payment for non-network providers**	Preauthorization required?	See page***
Prescription Drugs* (up to a 90-day supply for most drugs)				20-24, 36-38, 46, 47, 48, 49
• **Retail pharmacies**:** Annual prescription drug deductible applies. After you meet your annual prescription drug deductible, your cost-share limit for Tier 1 and Tier 2 drugs is: $75 per prescription for up to 30 days' supply, $150 per prescription for 31-60 days' supply, and $225 per prescription for 61-90 days' supply. Limit does not apply to Tier 3 drugs and prescription drug claims submitted by the enrollee.				
Tier 1: Generic drugs, all insulin, all disposable diabetic supplies, and certain specialty drugs (see page 24)	90% (enrollee coinsurance is 10% or cost-share limit, whichever is less)	90%	Certain drugs	
Tier 2: Preferred brand-name drugs	70% (enrollee coinsurance is 30% or cost-share limit, whichever is less)	70%	Certain drugs	
Tier 3: Nonpreferred brand-name drugs and compounded drugs	50%	50%	Certain drugs	
• **Mail-service pharmacy**:** Annual prescription drug deductible applies. If the actual price of the medication is less than the standard copay, you pay a minimum charge of $8.99 or the cost of the drug, whichever is greater—but not more than the standard copay.				
Tier 1: Generic drugs, all insulin, all disposable diabetic supplies, and certain specialty drugs (see page 24)	100% after $10 copay/refill	See note below	Certain drugs	
Tier 2: Preferred brand-name drugs	100% after $40 copay/refill	See note below	Certain drugs	
Tier 3: Nonpreferred brand-name drugs and compounded drugs	100% after $100 copay/refill	See note below	Certain drugs	

Please note: If you purchase prescription drugs from a mail-order or Internet pharmacy other than Express Scripts and submit claims yourself, prescription drug benefits will be paid as for a non-network retail pharmacy (see pages 20-21).

*Not subject to the annual medical/surgical deductible.

** Your cost-share for these services does not count towards the annual medical/surgical out-of-pocket limit, and is exempt from that limit. See exception for out-of-network care on page 15.

*** Several exclusions listed in "Expenses Not Covered, Exclusions, and Limitations," may apply to all benefits. Please review the "Expenses Not Covered, Exclusions, and Limitations" section carefully.

All covered benefits are subject to the annual medical/surgical deductible unless otherwise noted. **Percentages shown in chart apply to the UMP allowed charge, which is the amount agreed upon by UMP network providers.**

Benefits	Plan payment for network providers	Plan payment for non-network providers**	Preauthorization required?	See page***
Preventive Care* Only certain services are covered as preventive care. See lists of covered services on pages 39-43.	100%	60%	No	38-43, 46
Radiation and Chemotherapy	90%	60%	No	44
Second Opinions				44
• When required by UMP*	100%	100%	No	
• When optional	90%	90%	No	
Skilled Nursing Facility 150 days max/year	100% after $200 copay/day; $600 max copay/person/year	60%	Yes	19, 44, 48, 49
Spinal and Extremity Manipulations 10 visits max/year	90%	60%	No	44, 48
Temporomandibular Joint (TMJ) Treatment (surgical)	90%	60%	Yes	19, 45
Tobacco Cessation Program* *Free & Clear* program only	100%	Not covered	No	45, 49
Vision Care*				45, 48, 49
• **Eye exams** (routine) Once per calendar year	90%	60%	No	
• **Vision hardware** Including frames, lenses, contact lenses, and fitting fees combined	$100 max plan payment every two calendar years	$100 max plan payment every two calendar years	No	
Well-Baby Preventive Care Services* See specific services covered under "Preventive Care"	100%	60%	No	39-41, 46

*Not subject to the annual medical/surgical deductible.

** Your cost-share for these services does not count towards the annual medical/surgical out-of-pocket limit, and is exempt from that limit. See exception for out-of-network care on page 15.

*** Several exclusions listed in "Expenses Not Covered, Exclusions, and Limitations," may apply to all benefits. Please review the "Expenses Not Covered, Exclusions, and Limitations" section carefully.

How the UMP PPO Works

While you may receive coverage for services performed by any approved provider type (see list on pages 15-17), your out-of-pocket expenses will be less if you use a UMP PPO network provider or network pharmacy. You'll be responsible only for any deductibles, enrollee coinsurance, and copayments along with expenses not covered (see the section starting on page 46), and charges that exceed benefit maximums/limits.

When Medicare is your primary coverage, professional providers who accept Medicare assignment may be considered network providers (see page 59). The UMP PPO network applies to you only in Washington State and the Idaho counties of Bonner, Kootenai, Latah, and Nez Perce.

If you use an out-of-network provider or a non-network provider or pharmacy, you'll also be responsible for amounts that exceed the UMP allowed charge (defined on page 71), in addition to your cost-sharing requirements and any expenses not covered.

When UMP PPO is the primary payer (see definition on page 78 and "If You Have Other Medical Coverage" on pages 58-61), network providers and network pharmacies will submit your claims and call to request any required medical review/preauthorization, saving you money on your share of the bill. If you use an out-of-network provider or a non-network provider or pharmacy, you'll be responsible for obtaining any required medical review/preauthorization, and you may have to pay for services and submit a claim form before you receive reimbursement from UMP PPO.

You and each covered dependent may choose different providers and decide whether to use UMP PPO network providers and network pharmacies.

Your Medical/Surgical Provider Options

Medical/surgical provider options are described below:

Network Providers

Refers to providers who have contracted directly with UMP or are part of a network that has contracted with UMP. Network providers agree to accept the UMP allowed charge as payment in full for services covered by UMP PPO. They cannot bill you for the difference between their billed charge and the UMP allowed charge. And using a network provider means you don't have to file claims. **Exception:** For services not covered by UMP PPO, network providers can bill their usual and customary charge.

For care in Washington, UMP directly contracts with a provider network that includes most acute care hospitals, nearly every major multispecialty clinic in the state, more than 11,000 physicians, and over 7,000 nonphysician health care professionals such as advanced registered nurse practitioners and physical, occupational, and speech therapists. We include additional alternative care providers (naturopaths, acupuncturists, and massage therapists) as network providers through an arrangement with the Alternáre network (a division of American WholeHealth Networks).

For care in the Idaho counties of Bonner, Kootenai, Latah, and Nez Perce — UMP has some direct contracts with network providers. Other providers in these counties are considered out-of-network providers (see page 77), since the UMP PPO network does not provide access to a full range of health care services.

For care elsewhere in the United States (other than Washington and the four Idaho counties identified above) — Access to network providers is through the Beech Street network, unless Medicare is your primary coverage. If Medicare is primary

and you see a provider who accepts Medicare, covered services will be paid as network whether the provider is in the Beech Street network or not. UMP coordination of benefits with Medicare covers most services in full (up to the Medicare allowed charge), regardless of network affiliation. See "UMP Provisions for Retirees on Medicare" on page 59.

See the summary tables starting on page 7 for the cost-sharing requirements that apply to services you receive from network providers. Your enrollee coinsurance (usually 10%) for care from a network provider does apply to your annual medical/surgical out-of-pocket limit once your annual medical/surgical deductible has been met.

Services covered as preventive care and preauthorized hospice services are covered at 100% of allowed charges when you use network providers.

To locate a network provider in Washington State, you may use the online provider directory on the UMP Web site at **www.ump.hca.wa.gov**, or call UMP Customer Service at 1-800-352-3968 or 425-686-1350 in the Seattle area. You may also get a printed copy of the directory from Customer Service. However, please note that you will receive the most up-to-date information by calling Customer Service, as provider status may change after the directory is printed.

For information on the Beech Street network:

Phone: 1-800-432-1776
Web site: www.beechstreet.com

Please be sure to use the Beech Street network directory only for care outside Washington and the four Idaho counties named above. While Beech Street has arrangements with providers in Washington and the four Idaho counties, these providers are not necessarily UMP PPO network providers.

Out-of-Network Providers

Refers to providers practicing in U.S. locations where there is no access to network providers, as well as to all providers outside the U.S. (see "Out-of-Network Provider(s) on page 77). In the Idaho counties of Bonner, Kootenai, Latah, and Nez Perce, any provider who does not contract with UMP or Alternáre (a division of American Whole-Health Networks) is considered an out-of-network provider.

UMP PPO's reimbursement rate is 80% of allowed charges, after your annual medical/surgical deductible has been met. Your enrollee coinsurance (20%) for care from an out-of-network provider *does* apply to your annual medical/surgical out-of-pocket limit. Out-of-network providers can also bill you for the difference between their billed charge and the UMP allowed charge (see definition on page 71).

Out-of-network, nonemergency services outside the U.S. must meet UMP criteria as explained under "Services Received Outside the U.S." on page 18.

Non-Network Providers

Refers to providers not contracted as a network provider but practicing in locations where you have access to network providers. (In other words, these providers are in areas where you could choose a network provider, but decide not to.) See the exception above regarding the four Idaho counties.

UMP PPO's reimbursement rate is 60% of allowed charges after your annual medical/surgical deductible has been met. Your enrollee coinsurance (40%) for care from a non-network provider does not apply to your annual medical/surgical out-of-pocket limit. Non-network providers can also bill you for the difference between their billed charge and the UMP allowed charge.

Providers Who Accept Medicare Assignment

If you are enrolled in Medicare and receive services from a provider who accepts Medicare assignment, the services will be paid at the network level.

Approved Provider Types

Only services performed by approved provider types are covered under UMP PPO. The list of approved provider types below includes individual medical professionals, hospitals and other facilities or organizations, pharmacies, and programs.

To bill UMP directly and receive payment in accordance with UMP PPO benefits, the provider must:

- Be of a type or specialty listed in this section;

- Have a current license, registration, or certificate to deliver services at their location;
- Perform only services within the provider's scope of practice, as defined by the licensing agency; and
- Provide services within UMP PPO's benefit limits.

"Approved" does not indicate whether a provider is network, out-of-network, or non-network.

Approved provider types include:

- Acupuncturists, licensed (LAc).
- Alcohol/Chemical Dependency Centers and Substance Abuse Treatment Facilities, licensed with Department of Social and Health Services (DSHS) certification (must be approved by UMP); non-PhD psychologists and mental health counselors employed by these facilities are covered only when delivering services within an approved substance abuse facility *and* the facility bills for their services.
- Ambulances, licensed ground or air service.
- Ambulatory Surgical Centers (ASC), licensed (Medicare-certified or accredited by the Joint Commission on Accreditation of Healthcare Organizations or other recognized national accreditation).
- Audiologists, certified.
- Biofeedback technicians, certified; covered only when employed by and delivering services within a hospital or other UMP-approved facility *and* the employing organization bills for their services.
- Birthing centers, licensed.
- Chiropractors, licensed (Doctors of Chiropractic [DC]).
- Community mental health agencies, licensed; non-PhD psychologists and counselors employed by these agencies are covered only when employed by and delivering services within a licensed community mental health agency *and* the agency bills for their services.
- Counselors, licensed, including Licensed Marriage and Family Therapists (LMFT), Licensed Masters of Social Work (LMSW), and Licensed Mental Health Counselors (LMHC).
- Dentists, licensed (Doctors of Dental Medicine [DMD] and Doctors of Dental Surgery or Dental Science [DDS]) (see page 27 for limits on dental services covered).
- Diabetes education programs (including Medical Nutrition Therapy), Medicare-approved or otherwise approved by UMP.
- Dieticians providing services in collaboration with an approved diabetes education program (see above).
- *Free & Clear* tobacco cessation program.
- Hearing aid fitters and dispensers, licensed.
- Home health aides, licensed (covered only when employed by and delivering services within a hospice or home health agency *and* that agency bills for their services).
- Home health or hospice agencies, licensed (Medicare-certified or accredited by the Joint Commission on Accreditation of Healthcare Organizations).
- Hospitals, licensed.
- Massage practitioners, licensed (LMP); only massage practitioners accepted into the UMP provider network are considered approved providers.
- Medical nutrition therapists (MNT), Medicare-approved or otherwise approved by UMP for the treatment of diabetes mellitus (see diabetes education programs) or chronic renal insufficiency, end-stage renal disease when dialysis is not received, or medical conditions up to 36 months after kidney transplant. MNTs are covered only when employed by and delivering services within a hospital or other UMP-approved facility *and* the employing organization bills for their services.
- Midwives, licensed (LM).
- Naturopaths, licensed (Naturopathic Doctors [ND]).

- Nurses, licensed including Licensed Advanced Registered Nurse Practitioners (ARNP) and Licensed Certified Nurse Midwives (CNM) (all types must be licensed); see Practical Nurses, Registered Nurses, and Registered Nurse First Assistants.
- Occupational therapists, licensed (OT).
- Optometrists, licensed (Doctors of Optometry [OD]).
- Pharmacists, licensed and registered (RPh) or Doctors of Pharmacy (PharmD).
- Pharmacies, licensed.
- Physical therapists, registered and licensed (RPT).
- Physicians, licensed (Doctors of Medicine [MD] or Doctors of Osteopathic Medicine [DO]).
- Physician Assistants, licensed (PA) (covered only when providing services under the supervision of a clinician *and* the clinician who is supervising bills for their services).
- Podiatrists, licensed (Doctors of Podiatric Medicine [DPM]).
- Practical Nurses, licensed (LPN) (covered only when employed by and delivering services within a hospital, skilled nursing facility, hospice, home health agency, or under the direction of a clinician *and* the employing organization or clinician bills for their services).
- Psychologists, licensed (PhD).
- Registered Nurses, licensed (RN) (covered only when employed by and delivering services within a hospital, skilled nursing facility, hospice, home health agency, or under the direction of a clinician *and* the employing organization or clinician bills for their services).
- Registered Nurse First Assistants, certified and licensed (covered only when employed by and delivering services within a hospital, skilled nursing facility, hospice, home health agency, or under the direction of a clinician *and* the employing organization or clinician bills for their services; only *Certified* Registered Nurse First Assistants are covered).
- Respiratory therapists, licensed (covered only when employed by and delivering services within a hospital, skilled nursing facility, hospice, home health agency, or under the direction of a clinician *and* the employing organization or clinician bills for their services).
- Skilled nursing facilities, licensed (Medicare-certified).
- Speech pathologists, licensed and certified by the American Speech, Language and Hearing Association.

Use of an approved provider type is not required for vision hardware purchases.

Coverage Outside Washington State

Services Received Outside Washington State, Inside the U.S.

UMP contracts with the Beech Street provider network for medical/surgical services outside of Washington State and the Idaho counties of Bonner, Kootenai, Latah, or Nez Perce. You will receive network-level benefits when you obtain services from a Beech Street network provider outside of Washington. The Beech Street network includes more than 400,000 providers throughout the United States. To find a Beech Street provider or to nominate a provider you see who is not currently in the Beech Street network, visit their Web site at **www.beechstreet.com** or call Customer Service at 1-800-352-3968.

Please note that while Beech Street also has network providers within Washington, only UMP providers are paid at the network level for services obtained in Washington State or the Idaho counties of Bonner, Kootenai, Latah, or Nez Perce.

If You Have Medicare As Primary Coverage

If you see a provider who accepts Medicare, your provider will be reimbursed at the network level

of benefits by UMP PPO. You do not have to see a Beech Street network provider if Medicare is your primary coverage.

Services Received Outside the U.S.

Health care services may be covered outside of the U.S. as long as they:

- Are provided by an approved provider type (see pages 15-17);
- Are medically necessary (see definition on pages 75-76);
- Are appropriate for the condition being treated;
- Are not considered to be experimental or investigational by United States standards; and
- Would otherwise be covered by UMP PPO.

These services are generally covered at the out-of-network benefit level once the annual medical/surgical deductible has been satisfied.

If you are seeking nonemergency services abroad, you may contact UMP to help you determine whether these services will be covered. As our toll-free numbers aren't available outside the U.S., you may use your secure e-mail through your UMP online access account. Or, you may use the Question/Feedback form on UMP's Web site at **www.ump.hca.wa.gov**. You may also write to us at:

Uniform Medical Plan
P.O. Box 34578
Seattle, WA 98124-1578

Foreign claims and any requested medical records must be translated into English with specific services, charges, drugs and dosage documented, along with the currency exchange rate.

Emergency Care

In cases of accidental injury or medical emergency, call 911 or seek care immediately. If a UMP network facility or provider is not available, you should obtain services from the most conveniently available approved provider. See the "Summary of Benefits" charts for coverage details.

Medical Review

Preauthorizing Services

UMP PPO includes a program to review and approve some medical services and supplies before, during, and after they're received. We have a medical review team to determine the appropriate treatment setting, whether the service or supply is medically necessary, if the service or supply has been accurately billed, and whether it is considered excessive. (The fact a service or supply is prescribed or furnished by an approved provider does not, by itself, make it medically necessary; see definition on pages 75-76).

This program discourages unnecessary care, saves money for you and UMP, and helps ensure treatment is consistent with standards of good medical practice. Remember, you and your provider always make the final decision to proceed with, postpone, or cancel any admission, treatment, supply, or procedure.

All claims for hospital admissions are subject to retrospective review for medical necessity. Medical reviewers may approve a proposed admission, deny it and suggest alternative methods, or require a second opinion from another specialist.

The following services must be preauthorized by UMP. Failure to obtain preauthorization prior to service may result in denial of your claim. To ensure you receive UMP PPO benefits, call 1-800-352-3968 or 425-686-1350 in the Seattle area for preauthorization before receiving these services. Preauthorization requests may be faxed directly to the Medical Review Department at 425-670-3197.

- *Certain injectable drugs* on that are not normally approved for self-administration, when obtained through a retail pharmacy or UMP's mail-service pharmacy (these drugs are indicated on the *UMP Preferred Drug List*).
- *Durable medical equipment, supplies, and prostheses:* Preauthorization is required for rentals beyond three months or for purchases over $1,000. UMP will not pay for additional costs beyond allowed charges for items preauthorized,

such as more costly equipment that serves the same medical purpose (for example, an electric wheelchair instead of a manual wheelchair).

It also may be to your benefit to request preauthorization on some frequently prescribed durable medical equipment (such as light boxes, hospital beds, and breast pumps). This helps us address potential coverage issues in advance.

- Home health care: Preauthorization is required for cases in which:
  - Visits are daily;
  - Visits are expected to exceed two hours a day; or
  - Length of treatment is expected to last more than three weeks.

  Reauthorization is required every two weeks unless determined otherwise by Medical Review. Call 1-888-759-4855 before starting home health services; otherwise, your claim will be denied if services are later determined not medically necessary or other home health care requirements are not met.
- Hospice care, including respite care: Hospice care from UMP PPO network providers is covered in full for up to six months when preauthorized. Respite care has a $5,000 lifetime maximum limit.
- Organ transplants: All organ transplants (including bone marrow, umbilical cord, and stem cell transplants) require preauthorization. You also must be accepted into the treating facility's transplant program and follow the program's protocol.

Other services requiring preauthorization:

- Cardiac/pulmonary rehabilitation.
- Cochlear implants.
- Genetic testing, except when associated with pregnancy or when associated with treatment decisions for a condition already diagnosed. Authorization may be granted only for testing performed by a specialist center/provider designated by UMP.
- Inpatient admissions for rehabilitation (physical, occupational, and speech therapy).
- Massage therapy in excess of one hour per treatment.
- Mental health partial hospitalization services (see page 32).
- Negative Pressure Wound Therapy Pumps and related services.
- Positron Emission Tomography (PET) scans, except for diagnosis or staging of cancer.
- Skilled nursing facility admissions.
- Temporomandibular joint (TMJ) surgery.

"Summary of Benefits," "Covered Expenses," and "Expenses Not Covered, Exclusions, and Limitations" contain more information on all services and supplies that require preauthorization.

Confirming Benefits

For services not requiring preauthorization, you may call UMP Customer Service to ask if those services are generally covered by UMP PPO. However, until a claim for services is actually submitted to UMP, UMP is unable to provide an accurate estimate of payment.

Medical Review During Claim Processing

When claims are processed, UMP will verify that treatment was medically necessary and will review provider charges. This may require the submission of medical records. UMP reserves the right of final determination in the amount payable for any service or supply.

Second Opinions

The UMP's medical reviewers may require a second opinion before approving an admission or procedure. When a second opinion is requested by UMP, it will be paid at 100% and not subject to the annual deductible requirement. Additionally, the

monies paid by UMP for the second opinion will not be counted towards your annual out-of-pocket limit. If you don't obtain a required second opinion, your benefits may be denied. See page 44 for information on second opinions you choose to get.

Case Management for Serious Illness

Optional Case Management

UMP offers an optional case management service at no cost for medical/surgical cases involving complex treatment or high expenses. These cases may be identified during the prenotification process, when hospitals notify UMP if you are admitted for a diagnosis that may require case management services. Optional case management services are performed under an agreement you and UMP enter before the case management begins.

Required Case Management

To promote quality health care, the UMP medical director may in some cases review medical records and determine that your use of certain services is potentially harmful, excessive, or medically inappropriate. Based on this determination, UMP may require you to participate in and comply with a case management plan as a condition of continued benefit payment. Case management may include designating a primary physician (MD or DO) to coordinate care, and designating a single hospital and pharmacy to provide covered services or medications. UMP has the right to deny payment for any services received outside of the required case management plan, except medically necessary emergency services.

You have the right to appeal the medical director's determination and the required case management plan through the process outlined under "Complaint and Appeal Procedures" starting on page 53.

Your Prescription Drug Provider Options

Although the prescription drug benefit differs based on whether drugs are purchased at a network or non-network pharmacy, or whether it is an enrollee-submitted claim, it does not differ based on geographic location. In addition to network and non-network retail pharmacies, you also have the choice of filling your prescriptions through our mail-service pharmacy. In most cases, you may receive up to a 90-day supply of medication, as prescribed by your physician, through either a retail or our mail-service pharmacy (see exception for specialty drugs on page 24).

Retail Pharmacies

UMP contracts with network pharmacies through Express Scripts, Inc. Network pharmacies are available nationwide, and have agreed to provide prescription drugs at a discounted rate when you present your UMP I.D. card. Although you may use any licensed pharmacy, a UMP network pharmacy will save you time and money by collecting only your annual prescription drug deductible and applicable enrollee coinsurance at the point of sale, and filing your claims for you. In addition, by using network pharmacies to file your prescription claims on your behalf, you will have the advantage of a cost-share limit on Tier 1 and Tier 2 drugs (see page 23). The Tier 1 and Tier 2 cost-share limit does not apply to paper claim forms submitted by an enrollee even if the drugs were purchased at a network pharmacy.

At non-network pharmacies, you will not receive a discounted rate; the Tier 1 and Tier 2 cost-share limit does not apply; and you are required to pay the full cost of the prescription at the pharmacy, submit the claim to UMP, and wait for reimbursement.

Transferring to a network pharmacy is easy. Just contact the network pharmacy of your choice, tell them you are a UMP PPO enrollee and would like

them to transfer your prescriptions from your current pharmacy. Be ready with the name and phone number of your current pharmacy as well as the prescription numbers or drug names and dosages. When you present your UMP I.D. card to the network pharmacy they will fill your prescription(s) and submit your claim(s) for you.

Here's how it works:

- You pay a coinsurance amount when purchasing at a network retail pharmacy, based on the drug's "tier" (see chart on page 23 for details).
- It is your responsibility to present your UMP I.D. card when purchasing prescription drugs at a network pharmacy so that you receive the UMP discounted price for the drug.

Mail-Service Pharmacy

If you have primary coverage other than UMP PPO that covers prescription drugs, don't send your prescription drug orders to UMP's mail-service pharmacy. You should use the mail-order feature of your primary plan. After your primary plan has processed your prescription, you may submit a paper claim form for secondary reimbursement by UMP PPO.

UMP PPO also offers prescription drugs through our network mail-service pharmacy. After you meet the annual prescription drug deductible, you pay a fixed dollar copayment per prescription or refill, based on the applicable drug "tier" as described in the chart on page 23. To order a prescription or refill by mail, you may visit the UMP Web site at **www.ump.hca.wa.gov**, or call Express Scripts Member Services at 1-866-576-3862.

Prescriptions faxed to the Express Scripts mail-service pharmacy MUST be faxed from the provider's office on the provider's letterhead with the following information: patient name, UMP I.D. number, and date of birth. Incomplete information may delay your prescription.

Internet or Other Mail-Order Pharmacies

UMP contracts exclusively with Express Scripts for mail-order prescription services. All other Internet or mail-order pharmacies are considered non-network. If you purchase prescriptions through a non-network mail order pharmacy, the following will apply:

- You will need to pay upfront for your prescriptions.
- You will need to submit a paper claim form for reimbursement (see page 52 for instructions).
- UMP will calculate payment as though you filled the prescription at a non-network retail pharmacy (see pages 20-21). There is no maximum enrollee cost-share limit for Tier 1 or Tier 2 prescriptions when using non-network pharmacies.
- If the pharmacy charges more than the UMP allowed charge, you will pay the difference.

To submit claims for prescriptions purchased from non-network pharmacies (either U.S. or foreign), see page 52 under "Filing a Claim."

Your Prescription Drug Benefit Amount

See "Prescription Drugs, All Insulin, and All Disposable Diabetic Supplies" on pages 36-38 for details on both the retail and mail-service pharmacy benefits.

The amount you pay for a prescription depends on the tier level the drug falls in (see table on page 23). Using generic and preferred drugs reduces costs both for you and for UMP. Generic drugs have the same active ingredient as their brand-name counterparts and are usually less expensive. The *UMP Preferred Drug List* (PDL) is a list of prescription drugs that have been identified as providing safe, cost-effective treatment. You may still choose nonpreferred drugs but you will generally pay more if you do.

UMP Preferred Drug List (UMP PDL)

State legislation requires that UMP conform to the Washington Preferred Drug List (Washington PDL), which is based on recommendations by the Washington State Pharmacy & Therapeutics Committee (P&T Committee). This independent group of practicing health care providers meets quarterly to help ensure that the content is medically sound and supportive of your health. The list is updated periodically as new information and drugs become available. Once these reviews are completed, the UMP PDL may change based on the P&T Committee's recommendations. The UMP PDL includes drugs from the Washington PDL and Express Scripts' National Formulary. UMP uses the Express Scripts' National Formulary for drug classes not yet reviewed by the Washington State P&T Committee.

Development and maintenance of the UMP PDL is a dynamic process. UMP retains the right to update the UMP PDL or shift medications to different tiers during the year if generic or over-the-counter alternatives become available, or if there are changes to the Washington PDL or Express Scripts' National Formulary. Please note that updates are made on a quarterly basis (January, April, July, and October) to the Washington PDL. The fact that a drug is preferred one quarter does not necessarily mean that it will be preferred through the end of the year. UMP will notify enrollees of changes made to the UMP PDL or Drug Coverage Management programs if these occur during the plan year.

Prescription Drug Benefits Summary

After you have met your annual prescription drug deductible, your cost-share for a prescription or refill is:

Tier	Enrollee's cost using network retail pharmacy (for up to a 90-day supply per prescription or refill)	Enrollee's cost at UMP's mail-service pharmacy (for up to a 90-day supply per prescription or refill)
Tier 1 Generic drugs, all insulin, all disposable diabetic supplies, and certain specialty drugs*	Lesser of 10% coinsurance or maximum enrollee cost-share limit (see below**)	$10 copay***
Tier 2 Preferred brand-name drugs	Lesser of 30% coinsurance or maximum enrollee cost-share limit (see below**)	$40 copay***
Tier 3 Nonpreferred brand-name drugs and compounded prescriptions	50% coinsurance Maximum enrollee cost-share limit does not apply	$100 copay***

**Certain specialty drugs are limited to a 30-day supply and may be subject to other restrictions. Brand-name specialty drugs with a generic equivalent are covered under Tier 3.*

*** **Enrollee cost-share limit:** For up to a 30-day supply, the limit is $75. For a 31- to 60-day supply, the limit is $150. For a 61- to 90-day supply, the limit is $225. The maximum enrollee cost-share limit does not apply to Tier 3 drugs or drugs purchased at a non-network pharmacy.*

**** If the actual price of the medication is less than the standard copay, you pay a minimum charge of $8.99 or the cost of the drug, whichever is greater—but not more than the standard copay.*

Enrollees who use the network mail-service pharmacy have the additional convenience of requesting refills online by accessing Express Scripts' Web site through the UMP Web site at **www.ump.hca.wa.gov**.

To find out which drugs are listed as preferred:

- Review the *UMP Guide to Preferred Drugs*;
- Visit the UMP Web site at **www.ump.hca.wa.gov** and link to the *UMP Preferred Drug List*; or
- Call Express Scripts, Inc. at 1-866-576-3862.

See "Covered Expenses" starting on page 25 and "Summary of Benefits" on pages 7-13 for more information on your prescription drug benefit.

Although in most cases you can receive up to a 90-day supply of your prescription drug, the actual supply also depends on the provider prescribing your medication. If your provider orders less than a 90-day supply, the pharmacist cannot give you more. At mail-service, if your prescription is for less than a 90-day supply, your copayment will not be prorated.

Limits on Drug Coverage

Some medications are covered by UMP PPO only for certain uses or in certain quantities. For example, since UMP PPO excludes cosmetic services and supplies, a drug will not be covered if used solely for cosmetic purposes meant to enhance physical appearance. Also, drug quantity may be limited to specific amounts over certain periods. In these cases, your doctor may need to provide more information to ensure coverage conditions are met.

UMP PPO may limit drugs to specific circumstances and protocols, or restrict initial and/or refill quantities where there is:

- Use outside the scope of UMP PPO benefits;
- A sound clinical basis;
- Inadequate evidence of cost-effectiveness; or
- Evidence that cost-effectiveness is lacking.

Certain prescription drugs are subject to quantity limits, as indicated on the *UMP Preferred Drug List*. For some of these drugs, you may request an exception by having your pharmacist or prescribing provider call Express Scripts at 1-800-417-8164. This review is usually completed while your pharmacist or provider is on the phone with Express Scripts. If you are not satisfied with the review decision, you may appeal (see "Complaint and Appeal Procedures" on pages 53-57).

Certain other drugs may require a coverage review process for preauthorization. To find out whether a certain drug is subject to review or quantity limits, or for specific questions on drug coverage management procedures or criteria, call Express Scripts at 1-866-576-3862, or visit the UMP Web site at **www.ump.hca.wa.gov**.

For preauthorization of injectable drugs that are not normally approved for self-administration, please call the UMP claims office at 1-800-352-3968.

Limits on Specialty Drugs

Drugs labeled as "specialty" on the *UMP Preferred Drug List* are limited to a 30-day maximum supply per prescription or refill. You may get your first prescription for a specialty drug filled at a retail pharmacy, but all subsequent prescriptions must be filled through CuraScript, UMP's specialty pharmacy vendor. You may contact CuraScript at 1-866-413-4135, 8 a.m. to 9 p.m. Eastern Time Monday-Friday; 9 a.m. to 1 p.m. Eastern Time Saturday. A patient care coordinator will contact you to arrange for delivery of your medication. Most specialty drugs are covered at the Tier 1 rate; however, brand-name specialty drugs with a generic equivalent are covered under Tier 3. All specialty drugs are limited to a maximum 30-day supply per prescription or refill.

What to Do if Drug Coverage Is Denied

If a network pharmacy (including mail-service and CuraScript for specialty drugs) informs you that coverage is denied, prior authorization is required, quantities are limited, or the prescription is otherwise not covered in full, your pharmacist or prescribing provider may contact Express Scripts at 1-800-417-8164. If applicable, your pharmacist or prescribing provider may initiate the Express Scripts' coverage review process at that time. A written determination will be sent to you and your provider within approximately two business days after Express Scripts has received information from your doctor needed for the coverage review. If Express Scripts informs your pharmacist or prescribing provider that a review is not allowed, you may appeal this decision through our appeals process (see pages 53-57).

If the medication is needed immediately, you may be eligible to receive a temporary supply during the review process. Ask your pharmacist to contact Express Scripts at 1-800-417-8164 for approval of a temporary supply.

See "Prescription Drugs, All Insulin, and All Disposable Diabetic Supplies" on pages 36-38 and "Complaint and Appeal Procedures" starting on page 53 for additional information and procedures related to prescription drug coverage.

Covered Expenses

The fact a physician or other provider prescribes, orders, recommends, or approves a service or supply does not, in itself, make it medically necessary (see pages 75-76).

UMP PPO benefits are payable only for medically necessary services and supplies provided in accordance with applicable medical review/preauthorization requirements, except as described for emergency care or coordination of benefits with other health plans (see pages 58-61). Services must be received from a UMP approved provider type (see list on pages 15-17), except as specifically noted. In most circumstances, UMP follows Medicare coverage guidelines. All benefits are subject to the exclusions and limits shown in "Summary of Benefits" and "Expenses Not Covered, Exclusions, and Limitations" as well as in this section. Be sure to check "Definitions" for a description of most terms used in this *Certificate of Coverage*.

Although UMP PPO strives to provide a full provider network in each geographic region, the fact services or supplies are listed does not necessarily mean network providers are available.

Most services are subject to the annual medical/surgical deductible. For details on the deductible and the annual medical/surgical out-of-pocket limit, as well as enrollee coinsurance and other cost-sharing, see "How the UMP PPO Works" and "Your Cost-Sharing Requirements."

As described in the "Summary of Benefits" charts and "How the UMP PPO Works," your level of coverage depends on the provider you use and where you receive care.

Except when coverage is required by law, you will be liable for the costs of any services or supplies received after your UMP PPO coverage ends.

The list of UMP PPO covered expenses follows:

Acupuncture

This benefit covers acupuncture treatments or office visits to obtain acupuncture up to a combined total of 16 visits per calendar year. See definition of "Limited Benefit" on page 75. Acupuncture is covered only when used as an anesthetic or to reduce pain (not instead of surgery).

Ambulance

If you frequently travel outside the U.S., you may want to purchase individual insurance for air ambulance services, as UMP PPO covers this transportation only to the nearest facility equipped to provide the treatment needed. The fact you or your doctor prefer that you be transported to the facility nearest your home is not a consideration.

When other transportation is not appropriate, this benefit covers ambulance services for a life-threatening illness or injury for transport:

- From the site of the medical emergency to the nearest facility equipped to treat the life-threatening illness or injury. See definition of medical emergency on page 75;
- From one facility to the nearest other facility equipped to give further treatment; or
- Home (if determined medically necessary; see definition on pages 75-76).

Charges for regularly scheduled passenger air and rail transportation from the site of the medical emergency to the nearest facility equipped to

For more information on what isn't covered and benefit limits, see "Summary of Benefits" and "Expenses Not Covered, Exclusions, and Limitations."

provide the treatment are covered for the patient only—for one round trip per calendar year.

Ambulance services are reimbursed at 80% of the UMP allowed charge.

If ground ambulance services are not appropriate for transporting to the nearest facility, emergency air ambulance will be covered if the situation is a medical emergency (see definition on page 75) and if air ambulance is the only appropriate method of transportation, based solely on UMP's determination of medical necessity.

Biofeedback Therapy

If used to treat a physical medical condition, such as hypertension (high blood pressure), biofeedback therapy is covered at normal plan payment levels. If used for mental health treatment, biofeedback therapy is covered under the mental health payment provisions and subject to annual visit limits.

Blood and Blood Derivatives

Blood and blood derivatives, including but not limited to synthetic factors, plasma expanders, and their administration, are covered.

Bone, Eye, and Skin Bank Services

Biologic materials supplied by human bone banks, eye banks, and skin banks are covered.

Cardiac and Pulmonary Rehabilitation

Cardiac and pulmonary rehabilitation that meet Medicare guidelines (not maintenance therapy) are covered when preauthorized.

Chemical Dependency Treatment

This benefit covers inpatient and outpatient chemical dependency treatment and supporting services, up to a maximum plan payment of $13,000 every 24 consecutive calendar month period. Chemical dependency is defined as an illness characterized by a physiological or psychological dependency on a controlled substance or on alcohol. For purposes of this benefit, treatment and services are medically necessary if recommended in the "Patient Placement Criteria for the Treatment of Substance Abuse-Related Disorders II" as published in 2001 by the American Society of Addiction Medicine. Chemical dependency does not include dependence on tobacco, caffeine, or food. Covered expenses include:

- Inpatient prescription drugs prescribed in connection with chemical dependency treatment (does not include prescriptions filled through retail or mail-order pharmacies, which are covered under "Prescription Drugs, All Insulin, and All Disposable Diabetic Supplies," starting on page 36).
- Inpatient treatment according to a prescribed provider plan at a hospital or substance abuse treatment facility, subject to approval by UMP's medical review program.
- Outpatient substance abuse diagnosis and treatment.

If you are not yet enrolled in a formal chemical dependency treatment program, medically necessary detoxification is covered as a medical emergency and is not included in calculating the dollar maximum under the chemical dependency treatment benefit.

Chiropractic Physician Services

See "Spinal and Extremity Manipulations" on page 44.

Dental Services

Most dental services are not covered as medical benefits under UMP PPO. For example, dental implants, orthodontic services, and treatment for damage to teeth or gums caused by biting, chewing, grinding, or any combination of these are not covered by UMP PPO. However, they may be covered by your PEBB dental plan.

Dental services covered by UMP PPO are limited to:

1. General anesthesia is covered when:
   - It is provided by an anesthesiologist in a hospital or ambulatory surgical center; and
   - The charges for the hospital or ambulatory surgical center are covered by UMP PPO.
2. Specific dental procedures that are performed in a hospital or ambulatory surgical center, but only if the services are medically necessary because the enrollee:
   - Is under the age of 7 with a dental condition that cannot be safely and effectively treated in a dental office; or
   - Has a dental condition that cannot be safely and effectively treated in a dental office because of a physical or developmental disability; or
   - Has a medical condition such that doing the procedure in a dental office would place the enrollee at undue risk.
3. Repair of accidental injury to natural teeth, including evaluation of the injury and development of a treatment plan. These repairs are covered, however, only if they are based on an evaluation and treatment plan completed within 30 days of the injury. Treatment may extend beyond 30 days if your provider determines treatment should start later or continue longer.
4. The following oral surgery procedures, whether performed by a dentist or a medical professional (other oral surgery is not covered):
   - Excision of tumors or cysts of the jaw, cheeks, lips, tongue, gums, roof and floor of the mouth, or restorative surgery required by the excision.
   - Incision of salivary glands or ducts.
   - Obturator maintenance for cleft palate, gum reduction for gingival hyperplasia due to Dilantin or phenytoin.
   - Jaw reconstruction due to cancer.
   - Reduction of a fracture or dislocation of the jaw or facial bones.

Diabetes Education

This benefit covers a diabetes education program approved by Medicare or otherwise authorized by UMP. The benefit follows Medicare protocol and criteria and includes services for:

- Newly diagnosed diabetics.
- Diabetics whose treatment regimen is changed from diet control to oral diabetes medication, or from oral diabetes medication to insulin.
- Diabetics with inadequate glycemic control as evidenced by an HbA1c level of 8.5% or more on two consecutive HbA1c determinations three or more months apart during the year before training begins.
- Persons who are at high risk for complications from inadequate glycemic control as indicated by lack of feeling in the foot or other foot complications such as foot ulcers, deformities or amputation, preproliferative or proliferative retinopathy or prior laser treatment of the eye, or kidney complications related to diabetes.

Diabetes education services must be prescribed by an approved provider type. To find an approved diabetes education program, visit the Web site **www.diabetes.org/education/edustate2.asp**. Services provided by dieticians in collaboration with an approved diabetes education program are covered.

For more information on what isn't covered and benefit limits, see "Summary of Benefits" and "Expenses Not Covered, Exclusions, and Limitations."

Diagnostic Tests, Laboratory, and X-Rays

This benefit covers:

- Diagnostic laboratory tests, x-rays (including diagnostic mammograms), and other imaging studies.
- Electrocardiograms (EKG, ECG).
- Electroencephalograms (EEG) and similar tests.
- Pathology exams.
- Screening and diagnostic procedures during pregnancy and related genetic counseling for prenatal diagnosis of congenital disorders.
- Studies and exams to establish a diagnosis or monitor the progress and outcome of therapy.

These tests must be appropriate to the diagnosis or symptoms reported by the ordering provider.

Colonoscopies for enrollees age 50 or over will be covered under the preventive care benefit regardless of diagnosis.

Positron Emission Tomography (PET) scans require preauthorization, except for cancer diagnosis or staging.

Genetic testing requires preauthorization (except when associated with pregnancy or when associated with treatment decisions for a condition already diagnosed). Authorization may be granted only for testing performed by a specialist center/provider designated by UMP.

Charges for Magnetic Resonance Imaging (MRI) are covered when determined medically necessary and appropriate to diagnose a specific condition.

Subject to U.S. Preventive Services Task Force guidelines, screening mammograms performed in conjunction with a covered routine physical exam are covered under the preventive care benefit.

In cases of alternative diagnostic approaches with different fees, UMP PPO will cover the least expensive, medically reliable diagnostic method.

Electron Beam Tomography (EBT), self-referred or prescribed by your provider, is not covered.

Dialysis

Outpatient professional and facility services necessary for dialysis are covered when prescribed by an approved provider type to treat a covered condition. Independent dialysis facilities are covered at 80% of allowed charges. Dialysis facilities within a hospital or skilled nursing facility setting are reimbursed based on the network, non-network, or out-of network status of the hospital.

Durable Medical Equipment, Supplies, and Prostheses

Preauthorization of durable medical equipment for rentals more than three months or purchases over $1,000 is required.

This benefit covers services and supplies that are prescribed by an approved provider type, are medically necessary, and are used to treat a covered condition, including:

- Artificial limbs or eyes (including implant lenses prescribed by a physician and required as a result of cataract surgery or to replace a missing portion of the eye).
- Breast pump for a medical condition of the mother or infant, such as a premature baby with difficulty sucking.
- Casts, splints, crutches, trusses, and braces.
- Contraceptive supplies that require a prescription, such as diaphragms.
- Diabetes care equipment (nondisposable) such as glucometers, sharps containers, insulin injection aids and insulin pumps, as well as accessories.
- Disposable diabetic supplies not purchased in a retail pharmacy or through our mail-service pharmacy.
- Foot care appliances for diabetics to prevent complications of diabetes.
- Initial external prosthesis and bra required by breast surgery, and replacement of these items when necessitated by normal wear, a change in

For more information on what isn't covered and benefit limits, see "Summary of Benefits" and "Expenses Not Covered, Exclusions, and Limitations."

medical condition, or additional surgery (also see "Mastectomy and Related Services" on pages 31-32).

- Ostomy supplies.
- Oxygen and rental equipment for its administration.
- Penile prosthesis when impotence is caused by a covered medical condition (not psychological), is a complication directly resulting from a covered surgery, or is a result of an injury to the genitalia or spinal cord *and* other accepted treatment has been unsuccessful.
- Rental or purchase (at UMP's option) of durable medical equipment such as wheelchairs, hospital beds, and respiratory equipment (combined rental fees cannot exceed full purchase price).
- Wig or hairpiece to replace hair lost due to radiation therapy or chemotherapy for a covered condition, up to a lifetime maximum of $100.

Equipment charges in excess of the charge for less costly equipment that serves the same medical purpose are not covered. It may help you to request preauthorization for frequently prescribed durable medical equipment items such as light boxes, hospital beds, and breast pumps. Otherwise, processing of these claims is suspended pending determination of medical necessity.

Durable medical equipment is covered at the network benefit rate only if you obtain the equipment or supply from a UMP PPO network durable medical equipment supplier or other network provider.

Disposable supplies to treat diabetes purchased at a retail pharmacy or through our mail-service program are covered under the "Prescription Drugs, All Insulin, and All Disposable Diabetic Supplies" benefit starting on page 36. Prescription drugs used in conjunction with durable medical equipment are also covered under the "Prescription Drugs, All Insulin, and All Disposable Diabetic Supplies" benefit.

Emergency Room

This benefit is subject to a separate $75 copay per visit in addition to your enrollee coinsurance and annual medical/surgical deductible. It covers emergency room facility charges for diagnosis and emergency treatment of a covered illness or injury. If UMP determines emergency care is not medically necessary or could be rendered in a nonemergency setting with equal effectiveness, no benefits will be paid for emergency room services. Charges for professional services by physicians and other providers may be billed separately and are paid according to payment rules for that provider type, service provided, and network status of the provider.

The emergency room copayment is waived if there is a direct hospital inpatient admission. However, the hospital inpatient services copayment or enrollee coinsurance will apply in these cases. See the "Summary of Benefits" for coinsurance/copayment details.

Some hospital-based physicians (such as anesthesiologists, radiologists, pathologists, emergency room doctors, etc.) who work in a network hospital or other facility may not be UMP network providers. If a non-network provider bills separately from the hospital and his or her billed charges exceed the UMP allowed charge, you owe the provider the difference.

Hearing Care

This benefit is limited to $400 per enrollee in any 36 consecutive months. It covers:

- Hearing exams and evaluations related to the purchase of a hearing aid.
- Purchase of a hearing aid (monaural or binaural) prescribed as a result of the exam/evaluation, including:
  - Ear mold(s).
  - Hearing aid instrument.

For more information on what isn't covered and benefit limits, see "Summary of Benefits" and "Expenses Not Covered, Exclusions, and Limitations."

  - Initial battery, cords, and other ancillary equipment.
  - Warranty and follow-up consultation within 30 days after delivery of hearing aid.
- Rental charges up to 30 days, if you return the hearing aid before actual purchase.
- Repair of hearing aid equipment.

To expedite claim payment for this benefit, submit the bills for the hearing exam and hearing aid purchase at the same time. Treatment for diseases/disorders of the ear or auditory canal (not related to a routine hearing exam) is covered as any other condition and not subject to the hearing care benefit limit.

Home Health Care

UMP preauthorization is required for home health care in which:

- Visits are daily;
- Visits are expected to exceed two hours a day; or
- Length of treatment is expected to last more than three weeks.

Reauthorization is required every two weeks unless otherwise approved by Medical Review. *Please call UMP at 1-888-759-4855 prior to the start of home health services in these cases.*

This benefit covers services provided and billed by a licensed home health agency to treat a covered illness or injury. Services must be part of a prescribed written treatment program. The provider must certify that you are homebound and that hospital or skilled nursing facility confinement would be required in the absence of home health care. Covered expenses include:

- Ancillary services such as intermittent care (less frequently than daily visits, and under two hours per visit) from home health aides and clinical social services, provided in conjunction with the skilled services of an RN, LPN, or physical, occupational, or speech therapist.
- Disposable medical supplies as well as prescription drugs provided by the home health agency.
- Home infusion therapy.
- Visits for part-time or intermittent skilled nursing care and for physical, occupational, and speech therapy.

Hospice Care (Including Respite Care)

If preauthorized, hospice care provided by network providers is covered at 100% of allowed charges. If not preauthorized, the normal UMP PPO benefit will apply.

This benefit covers hospice care for a terminally ill enrollee for up to six months. UMP may grant an extension if hospice care benefits have been exhausted. Services must be part of a written program of care developed by a state-licensed or Medicare-approved hospice.

The benefit includes:

- Inpatient services and supplies provided by the hospice when ordered by the attending provider such as prescription drugs, medical supplies normally used for inpatients, and rental of durable medical equipment.
- Respite care for a homebound hospice patient (continuous care of more than four hours a day to give family members temporary relief from caring for the patient), covered up to a $5,000 lifetime maximum.

Hospital Inpatient Services

This benefit covers hospital accommodation and the following inpatient services, supplies, equipment, and prescribed drugs to treat covered conditions:

- Blood and blood derivatives.
- Bone, skin, and eye bank services.
- Diagnostic tests and exams.
- General nursing care.

For more information on what isn't covered and benefit limits, see "Summary of Benefits" and "Expenses Not Covered, Exclusions, and Limitations."

- Prescription drugs administered during an inpatient stay.
- Radiation and x-ray therapy.
- Surgery.
- Take-home prescription drugs dispensed and billed by the hospital upon discharge.

Inpatient physical, occupational, and speech therapy require preauthorization.

When the hospital has only private rooms, UMP PPO will determine payment based on semiprivate room rates charged by other facilities in the area. Hospitals may bill you for the additional costs of certain high-cost services or devices that do not meet the medical necessity criteria of "the level of service, supply, or intervention recommended for this condition is cost-effective compared to alternative interventions, including no intervention." Examples of services for which there may be additional charges include metal-on-metal or ceramic hip prostheses. A *network* facility may not bill you for the difference between the standard service and the enhanced service, unless you agreed in writing to these charges prior to the service being provided.

In some cases, special-care unit accommodations, such as in a cardiac, intensive care, or isolation unit, may be covered based on the facility's special-care room rates.

Some hospital-based physicians (such as anesthesiologists, radiologists, pathologists, emergency room doctors, etc.) who work in a network hospital or other facility may not be UMP network providers. If a non-network provider bills separately from the hospital and his or her billed charges exceed the UMP allowed charge, you owe the provider the difference. Unless it's an emergency, take time to check the network status of any providers involved in your care before you receive services.

Hospital Outpatient Services

This benefit covers services for outpatient surgery, day surgery, short-stay obstetrical services (discharged within 24 hours of admission), or observation services of less than 24 hours. It also includes outpatient ancillary services such as lab, x-rays, radiation therapy, IV infusion therapy, and physical, occupational, and speech therapy.

Massage Therapy

To be covered by UMP PPO, a massage therapist must be a UMP network provider.

This benefit covers massage therapy to improve or restore function lost due to:

- An acute musculoskeletal illness or injury; or
- An exacerbation of a chronic musculoskeletal injury.

A maximum of 16 visits is covered per calendar year. Massage therapy exceeding one hour per session must be preauthorized.

Massage therapy services are covered only when prescribed for a diagnosed condition by a qualified clinician and based on a written treatment plan.

Please note that any visits applied to your deductible still apply to the annual visit maximum. See definition of "Limited Benefit" on page 75.

Mastectomy and Related Services

This benefit covers restorative surgery necessitated by previous surgery covered under UMP as well as mastectomy necessitated by disease, illness, or injury.

An enrollee receiving benefits in connection with a mastectomy who elects breast reconstruction in connection with the mastectomy is covered for:

- Reconstruction of the breast on which the mastectomy was performed.
- Surgery and reconstruction of the other breast to produce a symmetrical appearance.

- Prostheses.
- Physical complications of all stages of mastectomy, including lymphedemas.

Mental Health Treatment

This benefit covers hospital inpatient and outpatient services as well as professional services to treat neuropsychiatric, mental, or personality disorders, including eating disorders (bulimia and anorexia nervosa). Services from mental health providers for a mental health disorder are covered under this mental health treatment benefit, regardless of the cause of the disorder (such as postpartum depression).

Inpatient mental health treatment is limited to 10 days per calendar year. Outpatient mental health treatment is limited to 20 visits per calendar year. See definition of "Limited Benefit" on page 75. Visits for the sole purpose of medication management do not count toward the outpatient visit limit, and are instead covered as medical services.

As an alternative to inpatient care, UMP PPO covers partial hospitalization services. With preauthorization, partial hospitalization services may count toward inpatient benefit limits at a rate of two partial hospitalization days per inpatient day, until the 10-day limit on inpatient services has been met. Partial hospitalization services (see page 77) will be considered outpatient services for determining applicable enrollee coinsurance. If you reach the 10-day limit for inpatient services, or if you do not obtain preauthorization, partial hospitalization services will count toward the 20-visit limit for outpatient services.

Services of a licensed marriage and family counselor are covered only when provided to treat neuropsychiatric, mental, or personality disorders.

Biofeedback therapy is covered under this benefit when prescribed as part of an overall treatment plan for a mental health condition.

Mental health treatment must be provided or directed by one of the following:

- Licensed community mental health agency.
- Licensed nurse practitioner (ARNP) with training in psychology and counseling.
- Licensed physician.
- Licensed psychologist.
- Licensed Master of Social Work, Licensed Mental Health Counselor, or Licensed Marriage and Family Therapist.
- Licensed state hospital.

Services from non-PhD psychologists are covered under this benefit only when they are employed by and deliver services within a licensed community mental health agency *and* that agency bills for the services.

Mental Health Services and Your Rights

UMP and state law have established standards to:

- *Help ensure the competence and professional conduct of mental health service providers.*
- *Support your right to receive treatment only after informed consent.*
- *Protect the privacy of your medical information.*
- *Help you understand which services are covered under UMP PPO and the limits on your coverage.*

For more information about covered mental health services, or if you have a question or concern about your mental health benefits, please contact UMP.

If you think any mental health benefit you have received from UMP PPO may not conform to the terms of your coverage contract or your rights under the law, contact UMP at 206-521-2000. If you have a concern about the qualifications or professional conduct of your mental health provider, call the Washington State Department of Health at 1-800-525-0127 or their customer service department in Health Professions Quality Assurance at 360-236-4902.

For more information on what isn't covered and benefit limits, see "Summary of Benefits" and "Expenses Not Covered, Exclusions, and Limitations."

Naturopathic Physician Services

This benefit covers services of a naturopathic physician. Herbs and other nonprescription drugs, lotions, vitamins, or minerals prescribed as part of naturopathic care are not covered.

Neurodevelopmental Therapy for Children Ages 6 and Younger

Children ages 6 and younger are covered until their seventh birthday for neurodevelopmental therapy to assist with motor or sensory skill, such as speech therapy for developmental disorders of articulation, language therapy to correct developmental language delay, or diagnosis or treatment of learning disabilities. Benefits are payable only where significant deterioration in the child's condition would result without such services, or to restore and improve the child's functions.

Inpatient therapy is subject to the hospital inpatient copayment or enrollee coinsurance and limited to 60 days per calendar year. Outpatient care is covered up to 60 visits per calendar year for all therapies combined. See definition of "Limited Benefit" on page 75.

This benefit includes only the services of UMP approved provider types authorized to perform the therapy. Services must be part of a formal written treatment plan developed in consultation with the clinician diagnosing the condition and prescribing the therapy. The child is not eligible for both the "Physical, Occupational, and Speech Therapy" benefit and this benefit for the same type of services for the same condition.

Obstetric and Newborn Care

Genetic screening tests during pregnancy, including amniocentesis, do not require preauthorization by UMP. Genetic testing or screening outside of pregnancy requires preauthorization.

This benefit covers services for pregnancy and its complications when provided and billed by a licensed physician, nurse practitioner, licensed midwife or certified nurse midwife, hospital, or birthing center. Except in geographic areas where provider access is limited, the benefit includes only services provided by providers able to perform the full scope of obstetric services (prenatal, delivery, and postnatal care). Professional services include prenatal and postnatal care, amniocentesis and related genetic counseling and testing during pregnancy, prenatal testing (in accordance with the standards set forth in WAC 246-680-020), vaginal or cesarean delivery, and care of complications resulting from pregnancy. Hospital services are covered for obstetric care subject to the inpatient hospital copayment or enrollee coinsurance. Routine newborn nursery care will be covered during hospitalization of the mother receiving maternity benefits under this plan, and will not be subject to a separate copayment.

Newborn hospitalization for other than routine newborn care is covered subject to the hospital inpatient services copayment and/or enrollee coinsurance for the first 21 days from the date of birth, if the mother is covered by this plan.

Benefits for professional and other newborn follow-up care are also provided subject to any applicable deductible, copayment, or enrollee coinsurance amounts for the first 21 days from birth if the mother is covered by this plan. For newborn services beyond 21 days, the child must meet the plan's dependent eligibility as well as enrollment requirements, and any applicable premium must be paid.

For information on adding a new dependent to your coverage, see pages 66-67 (or call PEBB Benefit Services at 1-800-200-1004).

Services related to voluntary and involuntary termination of pregnancy are covered. Direct complications of infertility treatments (including selective fetal reduction) are not covered.

For more information on what isn't covered and benefit limits, see "Summary of Benefits" and "Expenses Not Covered, Exclusions, and Limitations."

Office, Clinic, and Hospital Visits

This benefit covers visits involving face-to-face interaction between patient and provider for diagnosis or treatment of covered conditions.

Family planning services (including contraceptive supplies requiring a prescription or fitting, or surgical implantation/insertion of contraceptive devices such as IUDs, cervical caps, and long-acting progestational agents) are covered as well.

This benefit also includes visits by the surgeon, assistant surgeon, and anesthesiologist in performing:

- Cosmetic, plastic, and reconstructive surgery, including related services and supplies, if necessary to improve or restore bodily function lost due to a nonoccupational accident occurring while you're covered, or a congenital anomaly (such as cleft palate or spina bifida) in a covered dependent child.
- Elective sterilization (tubal ligation and vasectomy).
- Mastectomy and related covered benefits (see pages 31-32).
- Surgery for a covered condition.
- Restorative surgery necessitated by previous surgery covered under UMP.

Organ Transplants

Preauthorization is required for organ transplants. This benefit covers services related to organ transplants (bone marrow and stem cell are considered organs for purposes of this benefit), including professional and facility fees for inpatient accommodation, diagnostic tests and exams, surgery, and follow-up care. Donor expenses are covered as defined below. Related services such as outpatient prescription drugs, and outpatient laboratory and x-rays may be covered under other UMP PPO benefits.

Organ transplants are covered only when preauthorized, performed in a plan-designated facility, and the services meet all of the following criteria:

- The service is required because of a disease, illness, or injury and is performed for the primary purpose of preventing, improving, or stabilizing the disease, illness, or injury.
- There is sufficient evidence to indicate that the service will directly improve the length or quality of the enrollee's life. Evidence is considered to be sufficient to draw conclusions if it is from published peer-reviewed medical literature (see definition on page 77), is well-controlled, directly or indirectly relates the service to the length or quality of life, and is reproducible both within and outside of research settings.
- The service's expected beneficial effects on the length or quality of life outweigh its expected harmful effects.
- The service is a cost-effective method available to address the disease, illness, or injury. "Cost-effective" means there is no other equally effective intervention available and suitable for the enrollee that is more conservative or substantially less costly.

In addition, you must have been accepted into the treating facility's transplant program and continue to follow that program's protocol.

Costs to remove the organ from the donor and to treat complications directly resulting from the surgery are covered by the recipient's UMP PPO coverage if the:

- Donor is not eligible for coverage under any other health care plan or government-funded program;
- Organ recipient is enrolled in UMP PPO; and
- Organ transplant meets the above coverage criteria.

Benefit Limitations: Transplants are covered only if preauthorized and performed in a plan-designated facility (see definition on pages 77-78). Cover-

For more information on what isn't covered and benefit limits, see "Summary of Benefits" and "Expenses Not Covered, Exclusions, and Limitations."

age of direct medical costs for bone marrow, stem cell, and umbilical cord donor searches is limited to a combined total of 15 donor searches per transplant. No other benefits are provided for services related to locating an organ transplant donor.

Outpatient/Day Surgery, Ambulatory Surgical Center (ASC)

This benefit covers services for outpatient surgery, day surgery, services at an ambulatory surgical center (ASC), or short-stay obstetric services (discharged within 24 hours of admission). Depending on the procedure, a separate surgical suite/facility charge is not covered in some circumstances. Although network providers cannot bill you for noncovered surgical suite/facility charges, you're responsible for these charges if billed by a non-network or out-of-network provider.

A doctor may be a network provider, yet perform services at a non-network day surgery/ASC. Be sure to confirm whether the facility is a UMP network provider prior to receiving services.

Phenylketonuria (PKU) Supplements

Phenylketonuria (PKU) supplements are covered when prescribed and used to treat PKU.

Physical, Occupational, and Speech Therapy

Inpatient physical, occupational, and speech therapy must be preauthorized.

This benefit covers inpatient and outpatient services to improve or restore function lost due to:

- An acute illness or injury;
- An exacerbation of a chronic injury; or
- A congenital anomaly (such as cleft lip or palate) in a covered dependent child.

Inpatient rehabilitation therapy services are covered to a maximum of 60 days per calendar year subject to the hospital inpatient copayment and/or enrollee coinsurance. If UMP determines inpatient care is not medically necessary or could be received in an outpatient setting with equal effectiveness, no benefits will be paid for inpatient care.

Outpatient therapy services are covered to a maximum of 60 visits per calendar year for all therapies combined. See definition of "Limited Benefit" on page 75.

Services must be part of a formal written treatment plan developed in consultation with the clinician who diagnosed your condition and prescribed the therapy.

UMP PPO will not cover the same type of services for the same condition under both this benefit and the "Neurodevelopmental Therapy" benefit.

Prescription Drugs, All Insulin, and All Disposable Diabetic Supplies

This benefit covers drugs that:

- Can be legally obtained only with a written prescription;
- ***Do not*** have an over-the-counter equivalent (see exceptions below); and
- Are approved by the Food and Drug Administration (FDA).

These include:

- Allergy antigens.
- Certain injectable prescription medications.
- Chemotherapeutic agents for treatment of malignancies.
- Contraceptive drugs.
- Fluoride supplements for prevention of dental caries in preschool children (see page 39).
- Methadone.
- Prescription prenatal vitamins (during pregnancy).

Certain nonprescription drugs and supplies are also covered including:

- All insulin and all disposable diabetic supplies such as test strips, lancets, sharps containers, and insulin syringes used in the treatment of diabetes.
- Over-the-counter prenatal vitamins (during pregnancy).
- Nicotine replacement therapy (NRT) when recommended for participants in the *Free & Clear* tobacco cessation program (see page 45). This program and covered medications are ***free of charge*** to enrollees.
- Prilosec OTC
- Other over-the-counter products and prescription drugs with over-the-counter equivalents that are specifically noted in the *UMP Preferred Drug List* (UMP PDL) as covered under Tier 1, Tier 2, or Tier 3.

To be covered, the above-listed prescription and non-prescription drugs and supplies ***must be accompanied by a written prescription*** from an approved provider type.

UMP PPO prescription drug benefits are payable only for medically necessary medications and supplies. Services must be received from a licensed pharmacy employing licensed registered pharmacists.

Prescriptions from both retail and mail-order pharmacies are subject to the $100 per person annual prescription drug deductible.

The amount you pay varies based on the following three drug "tiers" (categories):

Tier 1: Generic drugs, all insulin, all disposable diabetic supplies, and certain specialty drugs (see "Coverage for Specialty Drugs" on page 38)

Tier 2: Preferred brand-name drugs

Tier 3: Nonpreferred brand-name drugs and compounded prescriptions

See "Your Prescription Drug Benefit Amount" and the "Summary of Benefits" for additional information on the tiers and specific cost-sharing requirements.

An FDA-approved drug used for off-label indications (that is, prescribed for a use other than its FDA-approved label) is covered only if recognized as effective for treatment:

- In a standard reference compendium (defined on page 79).
- In most relevant peer-reviewed medical literature (defined on page 77), if not recognized in a standard reference compendium.
- By the federal Secretary of Health and Human Services.

No benefits will be provided for any drug when the FDA has determined its use to be contraindicated.

For more information on what isn't covered and benefit limits, see "Summary of Benefits" and "Expenses Not Covered, Exclusions, and Limitations."

Certain drugs may require preauthorization. In addition, UMP PPO may limit medications to specific circumstances and protocols or restrict initial and/or refill quantities where there is:

- A sound clinical basis.
- Inadequate evidence of cost-effectiveness.
- Evidence of lack of cost-effectiveness.

See "Limits on Drug Coverage" on page 24 for specific details.

You may receive up to a 90-day supply of medications at either a retail pharmacy or our mail-service pharmacy unless otherwise limited by the amount authorized by your prescriber, drug coverage management, preauthorization requirements, plan exclusions or limits, or drug availability. Specialty drugs (those that require special handling or administration) are limited to a 30-day supply; see page 38 for more information on how prescriptions for specialty drugs are handled.

See "Your Prescription Drug Provider Options" on pages 20-21 for more information on your choice of pharmacies.

UMP has a preferred drug list, which for many drug classes is based on the Washington Preferred Drug List (Washington PDL) used by several state programs. This list is developed using evidence-based criteria for safe, effective, and appropriate prescribing. Although your doctor may prescribe a preferred drug or any other drug he or she thinks is medically necessary for you, the amount you pay for your prescription depends on which tier it falls under (see page 23) and where you purchase it. Please note that some drugs are not covered by UMP PPO even when prescribed by your provider (see pages 46-49 for exclusions affecting drugs).

UMP retains the right to update the *UMP Preferred Drug List* (UMP PDL) or shift medications to different tiers during the year if generic or over-the-counter alternatives become available, or if there are changes to the Washington PDL or Express Scripts' National Formulary. Updates are made on a quarterly basis (January, April, July, and October) to the Washington PDL. The fact that a drug is preferred one quarter does not necessarily mean that it will be preferred through the end of the year. UMP will notify enrollees about any changes to the UMP PDL or the Drug Coverage Management programs if these occur during the year.

Please note that if you get a prescription medication and it turns out you cannot use it (for example, it doesn't work for you, or you have a reaction to it), UMP will not refund any part of the copayment or coinsurance, and you will have to pay the full copayment or coinsurance for any substitute prescription.

In many drug classes, when your prescribing provider indicates on your prescription for a non-preferred drug (including certain generic drugs) that substitution is allowed, your pharmacist will substitute the UMP preferred drug. This is a requirement under a state law that applies only to state-operated prescription drug programs (such as UMP) and prescribers who have endorsed the state's preferred drug list. You may ask your pharmacist to dispense the nonpreferred drug, but your out-of-pocket costs may be higher (Tier 3).

Mail-Service Pharmacy

Prescriptions faxed to the Express Scripts mail-service pharmacy MUST be faxed from the provider's office on the provider's letterhead with the necessary identifying information (patient name, UMP I.D. number, and date of birth). Otherwise, your prescription may be delayed while Express Scripts confirms the prescription.

You may order drugs by mail using our mail-service pharmacy, applying the same annual prescription drug deductible, preauthorization requirements, and limits as for retail prescription drugs. Prescriptions are usually delivered 10 to 14

business days after the Express Scripts mail-service pharmacy receives the prescription.

Prescriptions mailed or orders placed in December, but not filled until January 1 or after, will be subject to the annual prescription drug deductible applicable on the date the prescription is processed. Due to increased volume at the end of the year, UMP cannot guarantee that prescriptions submitted to our mail-service pharmacy in December will be processed during the current benefit year.

If there is a manufacturer shortage of a specific drug (or other shortage that our mail-service pharmacy cannot control), and the quantity available is less than the quantity you ordered, the copayment will not be prorated. The original copayment applicable for up to a 90-day supply is charged.

Coverage for Specialty Drugs

Drugs labeled as "specialty" on the *UMP Preferred Drug List* are limited to a 30-day maximum supply per prescription or refill. You may get your first prescription for a specialty drug filled at a retail pharmacy, but all subsequent prescriptions must be filled through CuraScript, UMP's specialty pharmacy vendor. You may contact CuraScript at 1-866-413-4135, 8 a.m. to 9 p.m. Eastern Time Monday-Friday; 9 a.m. to 1 p.m. Eastern Time Saturday. A patient care coordinator will contact you to arrange for delivery of your medication. Most specialty drugs are covered at the Tier 1 rate; however, brand-name specialty drugs with a generic equivalent are covered under Tier 3. All specialty drugs are limited to a maximum 30-day supply per prescription or refill.

Preventive Care

If you receive preventive services that exceed those listed here, they will not be reimbursed under UMP PPO's preventive care benefit. Instead, when medically necessary they will be reimbursed under the specific benefit the charges apply to (such as diagnostic tests, or laboratory and x-rays) and will be subject to the annual medical/surgical deductible. If your provider does not bill for a routine physical exam code and instead documents a diagnosis on your claim, the services are not considered preventive.

This benefit is not subject to the annual medical/surgical deductible. It covers the services in the tables that follow.

Benefits for well-baby care and routine physical exams for children and adults, including immunizations, were designed based on the U.S. Preventive Services Task Force guidelines, recommendations of the National Immunization Program of the Centers for Disease Control and Prevention, and recently published peer-reviewed literature on preventive care. Services are provided on an outpatient basis specifically to monitor and maintain health and to prevent illness.

When received from a UMP network provider, the specified preventive care services shown in this section are covered at 100% of allowed charges (no deductible, coinsurance, or copayments).

For more information on what isn't covered and benefit limits, see "Summary of Benefits" and "Expenses Not Covered, Exclusions, and Limitations."

Preventive Care: Covered Services

When the preventive care tables that follow show the recommended frequency of service as once a year, annually, or every one to three years, coverage will not be provided more often than once in 12 consecutive months. Preauthorization to waive this requirement may be requested by describing your individual circumstances to UMP in writing.

Children: Birth-6 years	
Screening exams	
Age	**Service covered**
2-4 days	Preventive health visit or home health visit, if your baby was discharged early.
Within 30 days	Preventive health visit.
2 months	Preventive health visit.
4 months	Preventive health visit.
6 months	Preventive health visit. Oral fluoride supplements for preschool children older than 6 months if primary water source deficient in fluoride.
9 months	Preventive health visit with hemoglobin/hematocrit and/or lead screening if child at risk.
12 months	Preventive health visit.
15 months	Preventive health visit.
18 months	Preventive health visit.
2-6 years	Annual preventive health visit.

Children: Ages 7-18 years	
Screening exams	
Age	**Service covered**
8 years	Preventive health visit.
8-18 years	HIV screening of adolescents at increased risk per U.S. Preventive Services Task Force guidelines, up to two tests annually.
10 years	Preventive health visit.
11-18 years	Up to annual preventive health visit.
18 years	Females: Pap smear and screening for chlamydia and gonorrhea (earlier if sexually active).

Children: Ages 2-18 years	
Immunizations: See immunization tables on next two pages for coverage of other immunizations.	
Age	**Service covered**
11 years or older	Meningococcal vaccine, if not administered previously.

The graph and explanation on the following pages represent the immunization schedule for children from birth to age 18 recommended by the National Immunization Program of the Centers for Disease Control and Prevention.

Recommended Childhood and Adolescent Immunization Schedule UNITED STATES • 2005

Vaccine ▼ / Age ▶	Birth	1 month	2 months	4 months	6 months	12 months	15 months	18 months	24 months	4–6 years	11–12 years	13–18 years
Hepatitis B[1]	HepB #1	HepB #2			HepB #3				HepB Series			
Diphtheria, Tetanus, Pertussis[2]			DTaP	DTaP	DTaP		DTaP			DTaP	Td	Td
Haemophilus influenzae type b[3]			Hib	Hib	Hib	Hib						
Inactivated Poliovirus			IPV	IPV	IPV					IPV		
Measles, Mumps, Rubella[4]						MMR #1				MMR #2	MMR #2	
Varicella[5]						Varicella			Varicella			
Pneumococcal Conjugate[6]			PCV	PCV	PCV	PCV			PCV		PPV	
Influenza[7]					Influenza (Yearly)				Influenza (Yearly)			
Vaccines below red line are for selected populations												
Hepatitis A[8]									Hepatitis A Series			

This schedule indicates the recommended ages for routine administration of currently licensed childhood vaccines, as of December 1, 2004, for children through age 18 years. Any dose not administered at the recommended age should be administered at any subsequent visit when indicated and feasible.

Indicates age groups that warrant special effort to administer those vaccines not previously administered. Additional vaccines may be licensed and recommended during the year. Licensed combination vaccines may be used whenever any components of the combination are indicated and other components of the vaccine are not contraindicated. Providers should consult the manufacturers' package inserts for detailed recommendations. Clinically significant adverse events that follow immunization should be reported to the Vaccine Adverse Event Reporting System (VAERS). Guidance about how to obtain and complete a VAERS form is available at www.vaers.org or by telephone, 800-822-7967.

Range of recommended ages

Only if mother HBsAg(–)

Preadolescent assessment

Catch-up immunization

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR DISEASE CONTROL AND PREVENTION

CDC SAFER • HEALTHIER • PEOPLE™

The Childhood and Adolescent Immunization Schedule is approved by:
Advisory Committee on Immunization Practices www.cdc.gov/nip/acip
American Academy of Pediatrics www.aap.org
American Academy of Family Physicians www.aafp.org

Footnotes

Recommended Childhood and Adolescent Immunization Schedule

UNITED STATES • 2005

1. **Hepatitis B (HepB) vaccine.** All infants should receive the first dose of HepB vaccine soon after birth and before hospital discharge; the first dose may also be administered by age 2 months if the mother is hepatitis B surface antigen (HBsAg) negative. Only monovalent HepB may be used for the birth dose. Monovalent or combination vaccine containing HepB may be used to complete the series. Four doses of vaccine may be administered when a birth dose is given. The second dose should be administered at least 4 weeks after the first dose, except for combination vaccines which cannot be administered before age 6 weeks. The third dose should be given at least 16 weeks after the first dose and at least 8 weeks after the second dose. The last dose in the vaccination series (third or fourth dose) should not be administered before age 24 weeks.

   Infants born to HBsAg-positive mothers should receive HepB and 0.5 mL of hepatitis B immune globulin (HBIG) at separate sites within 12 hours of birth. The second dose is recommended at age 1–2 months. The final dose in the immunization series should not be administered before age 24 weeks. These infants should be tested for HBsAg and antibody to HBsAg (anti-HBs) at age 9–15 months.

   Infants born to mothers whose HBsAg status is unknown should receive the first dose of the HepB series within 12 hours of birth. Maternal blood should be drawn as soon as possible to determine the mother's HBsAg status; if the HBsAg test is positive, the infant should receive HBIG as soon as possible (no later than age 1 week). The second dose is recommended at age 1–2 months. The last dose in the immunization series should not be administered before age 24 weeks.

2. **Diphtheria and tetanus toxoids and acellular pertussis (DTaP) vaccine.** The fourth dose of DTaP may be administered as early as age 12 months, provided 6 months have elapsed since the third dose and the child is unlikely to return at age 15–18 months. The final dose in the series should be given at age ≥4 years. **Tetanus and diphtheria toxoids (Td)** is recommended at age 11–12 years if at least 5 years have elapsed since the last dose of tetanus and diphtheria toxoid-containing vaccine. Subsequent routine Td boosters are recommended every 10 years.

3. ***Haemophilus influenzae* type b (Hib) conjugate vaccine.** Three Hib conjugate vaccines are licensed for infant use. If PRP-OMP (PedvaxHIB® or ComVax® [Merck]) is administered at ages 2 and 4 months, a dose at age 6 months is not required. DTaP/Hib combination products should not be used for primary immunization in infants at ages 2, 4 or 6 months but can be used as boosters after any Hib vaccine. The final dose in the series should be administered at age ≥12 months.

4. **Measles, mumps, and rubella vaccine (MMR).** The second dose of MMR is recommended routinely at age 4–6 years but may be administered during any visit, provided at least 4 weeks have elapsed since the first dose and both doses are administered beginning at or after age 12 months. Those who have not previously received the second dose should complete the schedule by age 11–12 years.

5. **Varicella vaccine.** Varicella vaccine is recommended at any visit at or after age 12 months for susceptible children (i.e., those who lack a reliable history of chickenpox). Susceptible persons aged ≥13 years should receive 2 doses administered at least 4 weeks apart.

6. **Pneumococcal vaccine.** The heptavalent **pneumococcal conjugate vaccine (PCV)** is recommended for all children aged 2–23 months and for certain children aged 24–59 months. The final dose in the series should be given at age ≥12 months. **Pneumococcal polysaccharide vaccine (PPV)** is recommended in addition to PCV for certain high-risk groups. See *MMWR* 2000;49(RR-9):1-35.

7. **Influenza vaccine.** Influenza vaccine is recommended annually for children aged ≥6 months with certain risk factors (including, but not limited to, asthma, cardiac disease, sickle cell disease, human immunodeficiency virus [HIV], and diabetes), healthcare workers, and other persons (including household members) in close contact with persons in groups at high risk (see *MMWR* 2004;53[RR-6]:1-40). In addition, healthy children aged 6–23 months and close contacts of healthy children aged 0–23 months are recommended to receive influenza vaccine because children in this age group are at substantially increased risk for influenza-related hospitalizations. For healthy persons aged 5–49 years, the intranasally administered, live, attenuated influenza vaccine (LAIV) is an acceptable alternative to the intramuscular trivalent inactivated influenza vaccine (TIV). See *MMWR* 2004;53(RR-6):1-40. Children receiving TIV should be administered a dosage appropriate for their age (0.25 mL if aged 6–35 months or 0.5 mL if aged ≥3 years). Children aged ≤8 years who are receiving influenza vaccine for the first time should receive 2 doses (separated by at least 4 weeks for TIV and at least 6 weeks for LAIV).

8. **Hepatitis A vaccine.** Hepatitis A vaccine is recommended for children and adolescents in selected states and regions and for certain high-risk groups; consult your local public health authority. Children and adolescents in these states, regions, and high-risk groups who have not been immunized against hepatitis A can begin the hepatitis A immunization series during any visit. The 2 doses in the series should be administered at least 6 months apart. See *MMWR* 1999;48(RR-12):1-37.

Preventive Care: Covered Services

When the preventive care tables that follow show the recommended frequency of service as once a year, annually, or every one to three years, coverage will not be provided more often than once in 12 consecutive months. Preauthorization to waive this requirement may be requested by describing your individual circumstances to UMP in writing.

Men: Ages 19 Years and Older	
Screening exams	
Age	**Service covered**
19-64 years	Preventive health visit every 1-3 years.
19+ years	Fasting blood glucose testing every 1-3 years for patients with established diagnosis of hypertension or established diagnosis of hyperlipidemia.
19-21 years	HIV screening of adolescents at increased risk per U.S. Preventive Services Task Force guidelines, up to two tests annually.
35-65 years	Blood cholesterol/lipids screening every 5 years.
50+ years	Fecal occult blood test for colorectal cancer at each preventive health visit.
50+ years (or younger if at risk)	Flexible sigmoidoscopy once every 48 months. Colonoscopy once every 10 years, but not within 48 months of screening sigmoidoscopy.
50+ years	PSA (Prostate Specific Antigen) once a year at physician discretion.
65+ years	Preventive health visit once a year.
65-75 years	One-time screening ultrasound for Abdominal Aortic Aneurysm, for current or prior tobacco users.
Immunizations	
Age or other indications	**Service covered**
19+ years	Tetanus/Diptheria (Td) booster once every 10 years (or more frequently if injured).
19+ years	Varicella (if no history of chickenpox and not previously immunized).
19+ years	Influenza vaccine, annually.
19+ years	Meningococcal vaccine—for college students, post-splenectomy patients, or as indicated for patients with chronic illness.
40 years	Measles/Mumps/Rubella (MMR) second dose if not administered previously.
65+ years (or younger with chronic illness)	Pneumococcal vaccine—once; plus one-time revaccination five years later for patients with chronic illness or post-splenectomy patients.

Annual exams from OB/GYNs count as a routine preventive health visit. Women may get only one routine exam under the preventive care benefit in a 12-month period. If you go to a gynecologist for your routine exam, make sure the provider knows this is your preventive care visit for the year. If you get more than one routine exam in a 12-month period, it may be paid under the medical/surgical benefit (and therefore subject to coinsurance and any deductible owed), or denied, depending on how the visit is billed by your provider.

Preventive Care: Covered Services

When the preventive care tables that follow show the recommended frequency of service as once a year, annually, or every one to three years, coverage will not be provided more often than once in 12 consecutive months. Preauthorization to waive this requirement may be requested by describing your individual circumstances to UMP in writing.

Women: Ages 19 and Older	
Screening exams	
Age	**Service covered**
19-64 years	Preventive health visit every 1-3 years.
19+ years	Fasting blood glucose testing every 1-3 years for patients with established diagnosis of hypertension or established diagnosis of hyperlipidemia.
19-21 years	HIV screening of adolescents at increased risk per U.S. Preventive Services Task Force guidelines, up to two tests annually.
19-39 years	Pap smear and pelvic exam annually or every 1-3 years as recommended by your provider (annual chlamydia and gonorrhea screening through age 24).
40+ years	Mammogram every 1-2 years depending on risk factors. Pap smears and pelvic exams every 1-3 years.
45-65 years	Blood cholesterol/lipids every 5 years; after age 65, at physician discretion based on risk factors.
50+ years	Fecal occult blood home test for colorectal cancer during each preventive care visit.
50+ years (or younger if at risk)	Flexible sigmoidoscopy once every 48 months. Colonoscopy once every 10 years, but not within 48 months of sigmoidoscopy.
65+ years	Preventive health visit once a year.
65+ years	Bone density screening using a combination of validated risk questionnaires and densitometry techniques every two years; may begin at age 60 if at risk.
Immunizations	
Age or other indications	**Service covered**
19+ years	Tetanus/Diptheria (Td) booster once every 10 years (or more frequently if injured).
19+ years	Varicella (if no history of chickenpox and not previously immunized).
19+ years	Influenza vaccine, annually.
19+ years	Meningococcal vaccine—for college students, post-splenectomy patients, or as indicated for patients with chronic illness.
Childbearing age, but not during pregnancy	Measles/Mumps/Rubella (MMR) second dose (discuss with provider).
65+ years (or younger with chronic illness)	Pneumococcal vaccine—once; plus one-time revaccination five years later for patients with chronic illness or post-splenectomy patients.

Radiation and Chemotherapy

This benefit covers therapeutic application of radiation and chemotherapy.

Second Opinions

This benefit covers:

- Second opinions required under UMP's medical review/preauthorization or case management program (failure to obtain a second opinion when required may cause denial of benefits).
- Second opinions you choose to have, without UMP requirements.

Except in an emergency, a second opinion is almost always a good idea before any major procedure or treatment program. The benefit of a second opinion may be greatest if you:

- Tell your attending physician you would like a second opinion.
- Try to get your opinion from a doctor unaffiliated with the first (preferably practicing at another institution).
- Consider seeking a second opinion on surgery from a non-surgeon.
- Let the second opinion provider know that you expect to have a thorough review of records, interview, and physical exam.

Required second opinions are covered at 100% of the allowed charge and are not subject to the annual medical/surgical deductible.

Skilled Nursing Facility

Preauthorization is required for inpatient skilled nursing facility benefits.

This benefit covers accommodations, services, and supplies to treat an accidental injury, illness, or other covered condition–when provided in and billed by a state-licensed, Medicare-certified skilled nursing facility.

You must require continued services of skilled medical or allied health professionals that cannot be provided on an outpatient basis. Benefits are limited to 150 days per calendar year, unless UMP approves additional coverage in place of inpatient hospitalization.

Skilled nursing facility confinement for individuals with mental health conditions or retardation, or for care that is primarily domiciliary, convalescent, or custodial in nature is not covered.

Spinal and Extremity Manipulations

Manipulations of the spine or extremities, performed by a chiropractor, osteopathic physician, or other approved provider type, including related office visits and diagnostic tests/x-rays, are covered to a combined total of 10 visits per calendar year. (One or more of these services performed in a single encounter will count as one visit.) See definition of "Limited Benefit" on page 75.

Any diagnostic test, treatment, or x-ray required to diagnose or treat spinal subluxations or extremity disorders will be denied once the 10-visit limit has been reached.

Patient education or complementary and preparatory services are not separately reimbursed by UMP PPO. UMP defines complementary and preparatory services as interventions that are used to prepare a body region for or facilitate a response to a spinal and extremity manipulation/adjustment. The application of heat or cold, or pre-manipulation exercise programs, are considered complementary and preparatory services.

For more information on what isn't covered and benefit limits, see "Summary of Benefits" and "Expenses Not Covered, Exclusions, and Limitations."

Telemedicine Services

This benefit covers certain limited services provided through telehealth communications technology. Such services must be provided by a provider who is:

- A specialist contracted with UMP;
- Located at a site other than where the patient is located; and
- Of a physician specialty not available in the community where the patient lives, or is a psychologist or speech pathologist.

Interactive audio and video telecommunications must be used, with real-time communication between the specialist and patient.

Covered services are limited to consultations, outpatient visits, certain mental health services and assessments, diabetes self-management training through an approved program, monitoring of dialysis patients, and some speech and hearing services.

A referral from an approved provider type is required for covered consultation services.

The site where the patient is located must be in a rural area where there is a shortage of specialists and can be:

- A provider's office;
- A community mental health center;
- A hospital;
- A rural health clinic; or
- A federally qualified health center.

This benefit does not include:

- E-mail, telephone, and facsimile transmissions.
- "Store and forward" technology (transmission of medical information reviewed at a later time by physician or practitioner at distant site).
- Installation or maintenance of any telecommunication devices or systems.
- Home health monitoring.
- Online medical evaluations using Internet or similar communications network.

Temporomandibular Joint (TMJ) Treatment

Surgical treatment for TMJ disorders is covered when preauthorized. Medical or dental treatment for TMJ disorders is not covered.

Tobacco Cessation Program

This benefit is covered in full and not subject to the annual medical/surgical deductible.

The benefit covers services by the *Free & Clear* tobacco cessation program only, which provides phone counseling and education materials. If nicotine replacement therapy, Zyban, or other drugs are advised by *Free & Clear* counselors, with a prescription obtained from your provider, the medications will be covered under the prescription drug benefit. These authorized prescription drugs are not subject to the annual prescription drug deductible or enrollee coinsurance/copayment.

For more details or to enroll in the program, call 1-800-292-2336.

Tobacco or smoking cessation programs other than *Free & Clear* are not covered.

Vision Care (Routine)

This benefit is not subject to the annual medical/surgical deductible. It covers routine eye exams, including refractions, once each calendar year.

An allowance of $100 toward prescription eyeglass lenses, frames, contact lenses, and fitting fees is provided every two calendar years and is not subject to enrollee coinsurance.

You can shop anywhere for your vision hardware; your maximum benefit of $100 applies regardless of where obtained. If you go to a provider that does not bill UMP, it is easy to submit a claim for glasses or contacts; see pages 50-52 for instructions.

For more information on what isn't covered and benefit limits, see "Summary of Benefits" and "Expenses Not Covered, Exclusions, and Limitations."

Expenses Not Covered, Exclusions, and Limitations

UMP PPO covers only the services and conditions specifically identified in this *Certificate of Coverage*. Unless a service or condition fits into one of the specific benefit definitions, it is not covered. If you have questions, call Customer Service at 1-800-352-3968.

Here are some examples of common services and conditions that are not covered. Many others are also not covered—these are examples only, not a complete list.

1. Acupuncture, except as described under "Acupuncture" on page 25.
2. Additional portion of a physical exam beyond what is covered by the preventive care benefit (starting on page 38), such as that required for employment, travel, immigration, licensing, or insurance and related reports.
3. Alcohol/drug information or referral services or enrollment in Alcoholics Anonymous or similar programs such as services provided by schools or emergency service patrol.
4. All procedures involving selection of embryo for implantation.
5. Air ambulance, if ground ambulance would serve the same purpose, or transportation by "cabulance" or other nonemergency service.
6. Charges for completing forms or copying records, except for records requested by UMP to perform retrospective utilization review.
7. Circumcision, unless determined medically necessary for a medical condition.
8. Complications directly arising from services not covered.
9. Conditions caused by or arising from acts of war.
10. Cosmetic services or supplies, including drugs and pharmaceuticals, except for:
    - Reconstructive breast surgery following a mastectomy necessitated by disease, illness, or injury.
    - Reconstructive surgery of a congenital anomaly in a covered dependent child.
    - Restoring function.
11. Court-ordered care, unless determined by UMP to be medically necessary and otherwise covered.
12. Custodial care (see definition on page 72).
13. Dental care for the treatment of problems with teeth or gums, other than the specific covered dental services listed on page 27.
14. Dietary or food supplements, including:
    - Herbal supplements, dietary supplements, medicinal foods, and homeopathic drugs;
    - Infant or adult dietary formulas, except for treatment of congenital metabolic disorders detected by newborn screening such as phenylketonuria (PKU) when specialized formulas have been established as effective for treatment;
    - Minerals; and
    - Prescription or over-the-counter vitamins (except prenatal vitamins during pregnancy).
15. Drugs or medicines not prescribed by an approved provider type, or not requiring a prescription, except as listed on page 36.
16. Educational programs except for:
    - Diabetes education services as described on page 27;
    - The *Free & Clear* tobacco cessation program described on page 45;
    - Medical nutrition therapy for:
        - Treatment of diabetes mellitus;
        - Chronic renal insufficiency;
        - End-stage renal disease when dialysis is not received; or
        - Medical conditions up to 36 months after a kidney transplant.

17. Electron Beam Tomography (EBT), self-referred or prescribed by a provider.
18. Equipment not primarily intended to improve a medical condition or injury, including but not limited to:
    - Air conditioners or air purifying systems.
    - Arch supports.
    - Convenience items/options.
    - Exercise equipment.
    - Sanitary supplies.
19. Experimental or investigational services, supplies, or drugs, except for clinical trials consistent with Medicare coverage criteria.
20. Extracorporeal Shockwave Therapy: low-energy shock waves focused on a source of pain (soft tissue).
21. Foot care treatment for complaints such as corns and calluses, or fallen arches; and supplies for correction or treatment of such complaints, for example corrective shoes, orthotics, or related prescriptions. See "Durable Medical Equipment, Supplies, and Prostheses" on page 28 for coverage related to diabetes.
22. Hearing care services or supplies except as provided on pages 29-30. For example, the following are not covered:
    - A hearing aid that exceeds specifications prescribed for correction of hearing loss.
    - Charges incurred after plan coverage ends, unless the hearing aid was ordered before that date and is delivered within 45 days after UMP PPO coverage ends.
    - Expenses exceeding benefit limit (see "Hearing Care" on pages 29-30).
    - Purchase of batteries or other ancillary equipment, except those covered under terms of the initial hearing aid purchase.
23. Home health care except as provided on page 30. For example, the following are not covered:
    - 24-hour or full-time care in the home, unless preauthorized.
    - Any services or supplies not included in the home health care treatment plan or not specifically mentioned under "Home Health Care" on page 30.
    - Unless preauthorized:
      - Daily visits;
      - Visits exceeding two hours per day; or
      - Visits continuing for more than three weeks.
    - Dietary assistance.
    - Homemaker, chore worker, or housekeeping services.
    - Custodial care.
    - Nonclinical social services.
    - Psychiatric care.
    - Separate charges for records, reports, or transportation.
    - Services by family members or volunteer workers.
    - Services that are not medically necessary.
24. Homeopathic drugs, including products available only by prescription and approved by the U.S. Food and Drug Administration.
25. Hospice care except as provided on page 30. For example, the following are not covered::
    - Any services or supplies not included in the hospice care plan, not specifically mentioned under "Hospice Care" on page 30, or provided in excess of the specified limits.
    - Expenses for normal necessities of living such as food, clothing, or household supplies, Meals on Wheels, or similar services.
    - Homemaker, chore worker, or housekeeping services (except as provided by home health aides as part of the hospice program).
    - Legal or financial counseling.
    - Separate charges for records, reports, or transportation.
    - Services by family members or volunteer workers.
    - Services provided while the enrollee is receiving home health care benefits.
    - Services to other than the terminally ill enrollee including bereavement, pastoral, or spiritual counseling.

26. Hospital inpatient charges such as:
    - Admissions solely for diagnostic purposes that could be performed on an outpatient basis.
    - Beds "reserved" while the patient is being treated in a special-care unit or is on leave from the hospital.
    - High-cost services and devices that do not meet the medical necessity criteria of "the level of service, supply, or intervention recommended for this condition is cost-effective compared to alternative interventions, including no intervention." Examples include metal-on-metal or ceramic hip prostheses. See additional information under "Hospital Inpatient Services" on page 30.
    - Personal items (television, special diets not medically necessary to treat the covered condition, or convenience items).
    - Private room charges, unless medically necessary and preauthorized by UMP.
27. Immunizations, except as described under "Preventive Care" starting on page 38. Immunizations for the purpose of travel, employment, or required because of where you reside are not covered.
28. Impotence or sexual dysfunction treatment with drugs or pharmaceuticals, except during the three-month period following radical prostectomy.
29. Infertility or sterility testing or treatment, including drugs, pharmaceuticals, artificial insemination, and any other type of testing or treatment.
30. In vitro fertilization and all related services and supplies.
31. Learning disabilities treatment after diagnosis, except as described under "Neurodevelopmental Therapy" on page 33.
32. Maintenance therapy (see definition on page 75).
33. Manipulations of the spine or extremities, except as described under "Spinal and Extremity Manipulations" on page 44.
34. Marital, family, or other counseling or training services, except when provided to treat neuropsychiatric, mental, or personality disorders.
35. Massage therapy, unless services meet the criteria in "Massage Therapy" on page 31. Services from massage therapists who are not UMP network providers, and services (unless preauthorized) that exceed one hour per session are not covered.
36. Medicare-covered services or supplies delivered under a "private contract" with a provider who does not offer services through Medicare, when Medicare is the patient's primary coverage.
37. Mental, neuropsychiatric, or personality disorder treatment, except as described under "Mental Health Treatment" on page 32.
38. Missed appointments.
39. Non-network and out-of-network provider charges, as well as prescription charges from non-network pharmacies and enrollee-submitted claims, that are in excess of the plan's allowed charges.
40. Obesity treatment and treatment for morbid obesity, including any medical services, drugs, supplies, or any bariatric surgery (such as gastroplasty, gastric stapling, gastric banding, or intestinal bypass), regardless of co-morbidities, complications of obesity, or any other medical condition.
41. Organ donor coverage for anyone who is not a UMP PPO enrollee, or costs of locating a donor (such as tissue typing of family members), except as described under "Organ Transplants" on pages 34-35.
42. Organ transplants or related services in a facility that is not a "plan-designated facility" as defined on pages 77-78, or transportation or living expenses related to organ transplants.
43. Orthoptic therapy (eye training) or vision services, except as described under "Vision Care (Routine)" on page 45.

44. Over-the-counter drugs and products, except those listed on page 36 when prescribed by an approved provider type licensed to prescribe drugs.
45. Prescription drugs that have an over-the-counter equivalent product (see definition on page 77).
46. Recreation therapy.
47. Replacement of lost or stolen medications or medications confiscated or seized by Customs or other authorities.
48. Residential mental health treatment programs or care in a residential treatment facility.
49. Reversal of voluntary sterilization (vasectomy or tubal ligation).
50. Services or supplies to the extent benefits are available under any automobile medical, automobile no-fault, workers' compensation, personal injury protection, commercial liability, commercial premises medical, homeowner's policy, or other similar type of insurance or contract, if it covers medical treatment of injuries. (Benefits are considered available if they are payable under that other policy, or would be payable if you or someone else made a claim for them and complied with that insurer's claim procedures.) However, UMP PPO payments will be advanced upon request if you agree to apply for benefits under the other insurance or contract and to reimburse UMP PPO when settlement is received.
51. Services delivered by types of providers not listed as approved on pages 15-17, or by providers delivering services outside of the scope of their licenses.
52. Services of a non-PhD psychologist, except when employed by and delivering services within a community mental health agency *and* that agency bills for such services.
53. Services or supplies:
    - For which no charge is made, or for which a charge would not have been made if you had no health care coverage;
    - Provided by a family member;
    - That are solely for comfort (except as described in "Hospice Care" on page 30); or
    - For which you are not obligated to pay.
54. Services received outside of required case management when you are required to participate in and comply with a case management plan as a condition of continued benefit payment (see page 20 for details and exceptions).
55. Sexual disorder, diagnosis, counseling, or treatment.
56. Sexual reassignment surgery, services, counseling, or supplies.
57. Skilled nursing facility services or confinement:
    - For treatment of mental health conditions or retardation.
    - When primary use of the facility is as a place of residence.
    - When treatment is primarily custodial (see "Custodial Care" on page 72).
58. Surgical treatment to alter the refractive character of the cornea, such as radial keratotomy, photokeratectomy, or LASIK surgery.
59. Tobacco cessation services, supplies, or medications, except as described under "Tobacco Cessation Program" on page 45.
60. Weight-loss drugs, services, or supplies.
61. Wilderness training programs.

If you have questions about whether a certain service or supply is covered, call UMP at 1-800-352-3968 or 425-686-1350 in the Seattle area.

Filing a Claim

Medicare-enrolled retirees: Be sure to read "Coordination with Medicare" on page 60.

For Medical/Surgical Services

When Do I Need to Submit a Claim?

If you receive services from a non-network or out-of-network provider, you may need to submit a claim yourself. Also, if you have other insurance and UMP is not your primary payer, you may need to submit a claim for secondary payment, if your provider does not.

How Do I Submit a Claim?

To submit a claim yourself, you'll need to obtain and mail two documents:

1. The *Uniform Medical Plan Claim Form* — available on the UMP Web site at **www.ump.hca.wa.gov**, or by calling UMP Customer Service at 1-800-352-3968. You must fill out Sections 1, 2, 3, and 6 completely in order for the claim to be processed. Fill out Section 4 if the services were for a work-related illness or injury; fill out Section 5 if the patient has other insurance coverage.
2. A document from your provider that describes the services you received and the charges. This document could be a standard claim form ("CMS 1500" claim form for individual providers or a "UB-92" form for facilities), or it could in the form of a bill or an invoice. If you submit a standard form, your claim will be paid more quickly.

If your provider uses a non-standard claim form, the following information must appear on the provider's bill for the claim to be considered for payment:

- Patient's name and UMP identification number.
- Description of the illness or injury.
- Date and type of service.
- Provider's name.

If you have a claim form or bill from the provider, proof of payment (such as a receipt) is not required. However, if the only documentation you have is a receipt, send it in along with your completed claim form. Please note that if UMP has to request additional information, processing of the claim may be delayed.

Section 6 on the UMP claim form asks you whether you have paid the provider. If you check "Yes," UMP will send payment to you. If you check "No," UMP will send payment to the provider. For hospital claims, payment is almost always sent directly to the hospital, whether it is in the UMP network or not.

When UMP is your primary payer and your provider is in the UMP network, the provider will submit claims for you. So even if you get a bill from a network provider, don't send in a claim. If you have a question about whether a claim has been submitted, you may call UMP Customer Service at 1-800-352-3968.

Make copies of your documents. It is a good idea to keep a copy (or keep the original and send UMP a copy) of any documents.

Mail both the UMP claim form and the provider's claim document (or bill) to:

Uniform Medical Plan
P.O. Box 34850
Seattle, WA 98124-1850

What Can I Expect After Submitting a Claim?

Most claims are processed within four weeks. If you have a question about the status of a claim and haven't heard anything, we suggest waiting four weeks before calling. To inquire about a claim, call UMP Customer Service at 1-800-352-3968.

Delays may be due to a variety of causes, including insufficient information on the claim form, or UMP not having up-to-date information on any other insurance you or family members may have. Also, UMP may need to ask your provider for more information, which can take additional time.

When your claim has been processed, you will receive a document called an "Explanation of Benefits." This statement explains how your claim was processed, including: procedure code(s) for services provided, date of service, patient name, billed charges, UMP allowed charge, percentage paid by UMP, amount paid by UMP, amount you need to pay, and any amount applied to your deductible. Keep your original Explanation of Benefits and always make a copy if it needs to be sent elsewhere. UMP claims are calculated based on UMP PPO benefits as stated in this *Certificate of Coverage*.

Important Information About Submitting Claims

Claims must be submitted within 12 months of the date of service. UMP will not pay claims submitted by you or your provider more than 12 months after the date of service.

For additional instructions for services outside of the United States, see "Services Received Outside the U.S." on page 18.

Calculating Benefits When UMP PPO Is Your Primary Coverage: Some Sample Claims

The following examples illustrate how benefits for professional services are calculated when UMP PPO is the primary payer. Assume any annual deductible has been met, and any applicable out-of-pocket limit has not been reached.

Network provider			
Billed Charge	**UMP Allowed Charge**	**UMP PPO Pays**	**You Owe**
$1,000	$900	$810 (90% x $900)	$90 ($900-$810)
Non-network provider			
Billed Charge	**UMP Allowed Charge**	**UMP PPO Pays**	**You Owe**
$1,000	$900	$540 (60% x $900)	$460 ($1,000-$540)
Out-of-network provider (no access to network providers, or outside the U.S.)			
Billed Charge	**UMP Allowed Charge**	**UMP PPO Pays**	**You Owe**
$1,000	$900	$720 (80% x $900)	$280 ($1,000-$720)

If you or a family member has other health care coverage, see "If You Have Other Medical Coverage" on pages 58-61 for information on how UMP coordinates benefits with other plans.

Foreign claims for prescription drugs must be translated into English with specific services, charges, drugs and dosage documented, along with the currency exchange rate.

Who Gets the Money When Claims Are Paid

If you use a network provider, UMP sends payment directly to the provider. In most cases, you shouldn't pay a network provider until after UMP has processed the claim and determined your share of the bill.

However, network providers may request payment at the time services are provided when:

- You haven't met your annual medical/surgical deductible (and the services are subject to the deductible); or
- The services are not covered by UMP.

When payment is sent to the provider, UMP sends both you and the provider an Explanation of Benefits detailing how the claim was processed.

When payment is sent to you by UMP, a check will be attached to your Explanation of Benefits.

For Prescription Drugs

- If you use a UMP network retail pharmacy to fill your prescription and show your UMP I.D. card at the time you purchase your prescription, the pharmacy will file the claim for you. You will pay the pharmacy any coinsurance or deductible due at that time.
- If you use a non-network retail pharmacy (or do not show your I.D. card at a network pharmacy), you will have to file a *Prescription Drug Claim Form* yourself to receive reimbursement for UMP's share of the prescription costs.
- Also, if you get a prescription from a mail-order or Internet pharmacy other than Express Scripts' mail-service pharmacy, you will need to file a *Prescription Drug Claim Form* yourself for reimbursement.

For enrollee cost-sharing on claims that you submit using a *Prescription Drug Claim Form,* see page 52.

Prescription drug claims that you submit to UMP are subject to the same coverage rules as other prescriptions. This means that:

- If the claim you submit exceeds the quantity level limit allowed by UMP or the maximum days' supply, UMP will pay only for the amount of the drug up to the quantity level limit or maximum days' supply.
- If you submit a prescription drug claim and the prescription was ordered before it was eligible to be refilled, UMP will not pay for the prescription. (This is called a "refill too soon.")

If you do not show your UMP I.D. card when purchasing a prescription at a UMP network retail pharmacy, you will have to pay the full cash price and submit a Prescription Drug Claim Form. *In addition, the enrollee cost-share limit on Tier 1 and Tier 2 drugs does not apply to any claims that you submit via the* Prescription Drug Claim Form.

False Claims or Statements

Neither you nor your provider (or any person acting for you or your provider) may submit a claim for services or supplies that were not in fact received, were resold to another party, or for which you are not expected to pay.

In addition, neither you nor any person acting for you may make any false or incomplete statements on any document for your UMP PPO coverage.

UMP may recover any payments or overpayments made as a result of a false claim or false statement by withholding future claim payments, by suing you, or by other means.

Complaint and Appeal Procedures

Complaints

What Is a Complaint?

A complaint is an oral or written expression of dissatisfaction submitted by or for an enrollee regarding:

- Denial of coverage or payment for health care services or prescription drugs;
- Issues other than denial of coverage or payment, including dissatisfaction, delays, or conflicts with UMP or providers; or
- Dissatisfaction with UMP practices or actions unrelated to health care services or prescription drugs.

For access to secure e-mail, go to the UMP Web site at **www.ump.hca.wa.gov** *to sign up for your online access account. You may also e-mail complaints or appeals to UMP at* **umpappeals@hca.wa.gov.** *Please note that this is not secure, and private information should not be sent to this e-mail address.*

Complaints Not Involving Prescription Drugs

Complaints may be filed by mail, fax, phone, or e-mail.

If you want to make a complaint other than one relating to prescription drugs, call 1-800-352-3968 or 425-686-1350 in the Seattle area from 8 a.m. to 6 p.m. Monday through Friday (except holidays), or write UMP at:

Uniform Medical Plan
Correspondence
P.O. Box 34578
Seattle, WA 98124-1578

Fax: 425-670-3197

Complaints to UMP regarding medical or benefit issues, providers, and availability of health care will be referred to the UMP Medical Review Department for consideration. If you have a complaint or concern about a health care provider (such as a complaint related to a provider's conduct or ability to practice medicine safely), please contact the Department of Health by e-mail at **hpqa.csc@doh.wa.gov** or 360-236-4700, or visit its Web site (**https://fortress.wa.gov/doh/hpqa1/disciplinary/complaint.htm**) for more information.

Complaints related to nonmedical problems will be referred to the customer service or claims manager depending on the specific concern. Most complaints can be resolved at this level.

If you submit a written complaint, UMP will send confirmation of receipt within five business days. You will also receive notice of the action on your complaint within 30 calendar days of receiving your complaint, and usually sooner. UMP will notify you if additional time is needed for a response.

Complaints Relating to Prescription Drugs

If you are dissatisfied with issues related to your prescription drug benefit such as delays, customer service, or pharmacies, call Express Scripts at 1-866-576-3862 or communicate through UMP's Web site at **www.ump.hca.wa.gov**. Most complaints can be resolved at this level. But if your complaint cannot be resolved at this level, you may initiate an appeal within 180 days from the date the action occurred. See "First-Level Appeals" on pageS 55-56.

Prescription Drug Coverage Management

For certain drugs, UMP PPO limits quantity or therapeutic uses for which a drug can be covered over a specific period. Your provider may request coverage for these medications in excess of UMP limits if medically necessary. If you are adversely affected by a limit on a prescription drug that is subject to coverage review (see page 24), then your pharmacist or prescribing provider may call Express Scripts at 1-800-417-8164 to initiate drug coverage review for that particular medication. In some cases, your provider must contact Express Scripts

before a decision can be made. You may be eligible for a temporary supply while the coverage review is in process. However, if you choose to receive the drug outside UMP's conditions, you will be responsible for the full cost of any medications for which coverage is denied.

Appeals

What Is an Appeal?

An appeal is an oral or written request submitted by an enrollee or his or her authorized representative for UMP to reconsider:

- UMP's adverse decision regarding a complaint;
- A claim processing issue; or
- UMP's decision to deny, modify, reduce, or terminate payment, coverage, or authorization for health care services or prescription drugs.

You can also appeal decisions related to eligibility. Those include decisions where an adverse benefit decision is based on your not being eligible for coverage or not having paid premiums. Those appeals are handled separately. If your appeal involves those issues, call PEBB Benefit Services at 1-800-200-1004 or write to:

Health Care Authority
PEBB Appeals
P.O. Box 42699
Olympia, WA 98504-2699

General Information About Appeals

If you are appealing a decision to change, reduce, or terminate coverage for services already being provided, UMP is required to continue coverage for these services during your appeal. However, if the decision to change, reduce, or terminate coverage is upheld, you will be responsible for any payments made by UMP PPO during that period. If you are appealing to request payment for denied claims or approval of services not yet initiated, UMP PPO is not required to cover these services while the appeal is under consideration.

UMP will consult with a health care professional on appeals where the decision was based in whole or in part on a medical judgment. That includes decisions based on determinations that a particular treatment, drug, or other item is experimental, investigational, or not medically necessary or appropriate. The professional consulted in such a case will be one who has appropriate training and experience in the field of medicine involved.

Appeals may be filed by mail, fax, phone, or e-mail (see page 56).

You may send written comments, documents, and any other information to UMP when you appeal. You may also request copies of documentation UMP has that is relevant to your appeal, which will be provided at no cost. Our review will consider the information you submit to us, including material that was not considered in the initial benefit decision or earlier appeal.

Our review will not assume the earlier decision was correct; the reviewers will be different from those involved in the earlier decision, and not their subordinates.

Time Limits for UMP to Decide Appeals

The time limits below apply to both first- and second-level appeals, and are calculated from when UMP receives the appeal.

- The appeal decision will be made within 30 calendar days unless a shorter time limit applies as explained below. UMP will request written permission from you or your representative in cases where we recommend an extension to the 30-day timeline, to obtain medical records or a second opinion.
- In appeals involving a denial of a preauthorization request, the appeal decision will be made within 15 days.
- In a situation where delay could seriously jeopardize your life, health, or ability to regain maximum function, or where a physician who knows your condition tells UMP that delay would cause severe pain that could not be adequately managed without the care or treatment that is the subject of the appeal, the appeal decision will be

made as soon as possible but always within 72 hours (see "Expedited Appeals" below).

- If the adverse benefit decision was based on the conclusion that the service, drug, or device is experimental or investigational, the appeal decision will be made within 20 calendar days. If the appeal would otherwise have to be decided sooner than 20 days, the shorter time limit applies.

Expedited Appeals

If your coverage is denied and your provider determines a delay in coverage would seriously jeopardize your life, health, or ability to regain maximum function, ask your provider to request an expedited appeal. All clinically relevant information should be submitted. The provider should contact UMP by phone, fax, or e-mail at:

Phone: 206-521-2000
Fax: 206-521-2001
E-mail: umpappeals@hca.wa.gov

Due to privacy laws, UMP cannot share information on appeals or complaints with family members or other persons unless the patient is a minor, or UMP has received written authorization to release personal health information to the other person. If you would like someone else to handle your appeal, a Release of Information *form may be downloaded from UMP's Web site, or requested from Customer Service. If you request information about claims or appeals for a spouse, domestic partner, or child over the age of 13, you may be asked to provide written authorization from the patient to receive this information before we can release it to you.*

First-Level Appeals

First-level appeals may be initiated orally or in writing no more than 180 calendar days after you receive notice of the action leading to the appeal. Although appeals may be made by phone or in person, putting them in writing with all of the necessary information (see below for list) will speed up the process and provide for more informed decisions.

First-Level Appeals Not Involving Prescription Drugs

For appeals not involving prescription drugs, UMP will send confirmation of receipt within five business days. Claim processing disputes will be reviewed by an experienced claims examiner who did not process the original claim. Appeals about covering, authorizing, or providing health care will be evaluated by a medical review nurse not involved in the initial determination to deny, reduce, modify, or terminate services or benefits. If the medical review nurse's recommendation is to uphold denial of coverage, or a decision is made not to authorize services because they have been determined to be experimental or investigational, or not medically necessary, the appeal will be further reviewed and decided by the UMP medical director or associate medical director.

It is helpful if you include the following information when requesting an appeal:

- The subscriber's full name;
- The patient's full name;
- The UMP I.D. number (the one starting with a "W" on your I.D. card);
- The name(s) of any provider(s) involved in the issue you are appealing;
- The dates when services were provided;
- Your mailing address;
- Your phone number(s) (a good time to reach you by phone is useful too);
- Your e-mail address, if you have one;
- *Release of Information* form (see above), allowing UMP to request additional records from your provider or share information with someone else who is handling your appeal, if applicable; and
- Relevant medical records from your provider, if you can get them.

Send first-level appeals **not involving prescription drugs** to:

Uniform Medical Plan
Medical Review
First-Level Appeal
P.O. Box 34578
Seattle, WA 98124-1578

Fax: 425-670-3197

E-mail: Secure e-mail via your online access account, or to umpappeals@hca.wa.gov

First-Level Appeals Related to Prescription Drugs

You have the right to appeal if you or your provider disagrees with how your prescription drug claim was processed. That includes claims denial, reduction, or payment issues; applications of drug coverage management guidelines; medical necessity decisions; or drugs denied because of UMP PPO benefit exclusions. To appeal a coverage denial from Express Scripts, you (or your provider on your behalf) can appeal orally or in writing within 180 calendar days of the date you received your notification of denial. In cases involving denial of coverage based on coverage review guidelines or medical necessity decisions, your provider should supply clinically relevant information to Express Scripts. Therefore, it will speed up the process and provide for more informed decisions if your provider files these appeals for you.

Send first-level appeals **related to prescription drugs** to:

Express Scripts, Inc.
Attn: Pharmacy Appeals: WA5
6625 West 78th Street
Mail Route BLO390
Bloomington, MN 55439

Fax: 1-877-852-4070

Non-Provider Phone Number: 1-866-576-3862

Provider Phone Number: 1-800-417-8164

Second-Level Appeals

Second-level appeals must be submitted within 180 calendar days of UMP's decision regarding the first-level appeal. Any additional information you have to support your appeal should be submitted with your request to appeal a determination. For second-level appeals, UMP will send confirmation of receipt within five business days.

Send second-level appeals **not involving prescription drugs** to:

Uniform Medical Plan
Second-Level Appeal
P.O. Box 34578
Seattle, WA 98124-1578

Fax: 425-670-3197

E-mail: Secure e-mail via your online access account, or to umpappeals@hca.wa.gov

Send second-level **prescription drug appeals** to:

Uniform Medical Plan
Prescription Drug Appeal
P.O. Box 91118
Seattle, WA 98111-9218

Fax: 206-521-2001

E-mail: Secure e-mail via your online access account, or to umpappeals@hca.wa.gov

The second-level review will be performed by the UMP Appeals Committee, consisting of the UMP executive director or designee, UMP medical director or associate medical director, and director of compliance and enforcement or designee.

Independent Review

You may request an external or "independent" review in two situations. If you have appealed a decision to deny, modify, reduce, or terminate coverage of or payment for a health care service, you may request an independent review if UMP exceeds the timelines for response to your appeal without good cause and without reaching a decision. Also, you may request an independent review even if UMP has met all timelines but you are dissatisfied with the determination of your second-level appeal. To have an external review, you must ask UMP to send you the forms that must be completed and returned to UMP. These forms authorize UMP to release your medical information to the independent review organization. This process is explained in the letter you receive in response to your second-level appeal, or you may call the Appeals Department at 206-521-2000.

To request the forms for an independent review by mail, fax, phone, or e-mail:

Uniform Medical Plan
Independent Review Process
P.O. Box 91118
Seattle, WA 98111-9218

Fax: 206-521-2001
Phone: 206-521-2000
E-mail: umpappeals@hca.wa.gov

The external review will be done by an Independent Review Organization, or IRO. An IRO is a group of medical and benefit experts certified by the Washington State Department of Health and not affiliated with UMP in any way. An IRO is intended to provide unbiased, independent, clinical and benefit expertise as well as evidence-based decision making while ensuring confidentiality. UMP will pay the IRO's charges.

Any litigation against UMP must be brought in the Superior Court of Thurston County, Washington.

If You Have Other Medical Coverage

UMP PPO coordinates benefits with any other group health plan covering you so that your UMP PPO and other coverage combined will pay up to 100% of allowed charges (but not more than 100%). **Note:** This may result in your receiving one or more checks for "coordination of benefits (COB) adjustments" during the year. You receive this benefit adjustment because UMP PPO benefits were available but not needed for portions of claims paid by your primary plan. Those saved UMP PPO benefit dollars are later used to reimburse you for cost-share expenses (such as deductibles or coinsurance) that you paid for services earlier in that calendar year.

UMP PPO coordinates benefits with the following types of plans:

1. Group or blanket disability insurance policies, and health care service contractor and health maintenance organization group agreements, issued by insurers, health care service contractors, and health maintenance organizations.
2. Union trust health and welfare plans, multiple employer trust plans, or employee benefit organization plans.
3. Governmental programs (including, but not limited to, Medicare and Medicaid) and certain other coverage required or provided by any statute.

Benefits are not coordinated with any individual health coverage you have purchased, only with group plans.

The group insurance plan that is primary will process the claim first for all covered expenses. The primary plan will pay its normal benefit. The other plan(s) that cover you will be considered secondary and may pay less than their normal plan benefit, since total payments combined cannot exceed 100% of the allowed charges. When Medicare or another government program is one of the payers, federal law determines which plan provides benefits first.

For retirees enrolled in Medicare, UMP PPO is always secondary to Medicare for services covered by Medicare.

Who Pays First?

For coordination with plans other than Medicare, the following rules determine which plan is the primary payer. These rules apply in order, so the first rule below that applies to your situation will determine which plan is your primary coverage (subsequent rules ***do not*** apply):

For the Subscriber

- If a plan's contract or certificate of coverage does not say that the plan coordinates benefits, it pays primary before a plan that does coordinate benefits.
- The plan that covers the person as an active employee pays before a plan that covers that person as a retiree.
- If person has more than one employer and has coverage under multiple plans, then the plan that has covered the employee the longest is primary and pays first.
- The employer plan always pays first for an active employee also covered by Medicare.

For a Spouse or Same-Sex Domestic Partner Covered by a UMP PPO Subscriber

- If the spouse or same-sex domestic partner has other group health coverage, the other group plan pays first.
- If the spouse or same-sex domestic partner is also covered by Medicare and the subscriber is an active employee, UMP PPO pays first on the spouse's or same-sex domestic partner's claims.

For Dependent Children Covered by a UMP PPO Subscriber

- If a dependent child has coverage through his or her employment, the child's coverage pays before the parent's.
- Group plans will usually be primary over certain government programs in which some children may participate.

Dependent children of married parents:

- The plan of the parent whose birth month and day is earlier in the year pays first (for example, the plan of a parent born April 14 is primary over the plan of a parent born August 21).
- There is an exception to this "birthday rule" for newborn children. Washington law says that the mother's health plan must cover the newborn for the first 21 days of life, so the mother's plan pays first for all covered charges for the first 21 days of life. After that date, standard coordination rules as stated here apply to covered charges.

Dependent children of legally separated or divorced parents:

- Court decrees may require a non-custodial parent to provide coverage in which the standard rules for coordination of benefits apply, or may require a non-custodial parent to assume full financial responsibility for health care costs or coverage, in which case the standard rules may not apply. These cases will follow the orders of the court.
- In the absence of a specific court decree the following order of payment applies:
  1. The plan of the custodial parent.
  2. The plan of the custodial parent's spouse, if the custodial parent has remarried.
  3. The plan of the non-custodial parent.
  4. The plan of the spouse of the non-custodial parent, if the non-custodial parent has remarried.

Other Types of Plans

Group plans (including UMP PPO) are usually primary over certain federal programs, such as Medicaid and programs available to veterans, and certain federal retirees.

If UMP PPO is the primary payer, the UMP PPO payment will be your normal UMP PPO benefit.

If you have primary coverage other than UMP PPO that covers prescription drugs, don't send your prescription drug orders to UMP's mail-service pharmacy. You should use the mail-order feature of your primary plan. After your primary plan has processed your prescription, you may submit a paper claim form for secondary reimbursement by UMP PPO.

UMP Provisions for Retirees on Medicare

Retirees entitled to Medicare must be enrolled in Parts A and B. UMP PPO is not a Medicare supplement plan, as defined by the Washington State Insurance Commissioner.

When Medicare coverage is primary, UMP does not cover any services or supplies normally covered by Medicare and obtained through a "private contract" with a physician or practitioner who does not provide services through the Medicare program.

Retirees enrolled in Medicare pay lower premiums because Medicare is the primary payer for most services. UMP assumes the primary payer role for services and supplies not covered by Medicare, such as most outpatient prescription drugs and certain preventive care services.

If you have Medicare as your primary coverage and receive services from a provider who accepts Medicare assignment, the claim will be processed at the network benefit level. This applies throughout the U.S. Beech Street discounts do not apply for out-of-state claims. UMP coordination of benefits covers most services in full (up to the Medicare allowed charge) regardless of network affiliation, when you use providers who accept Medicare assignment.

Coordination with Medicare

Benefits are coordinated with Medicare in the same way as they are coordinated with other coverage.

In some cases, UMP will pay primary for retirees enrolled in Medicare when the service or supply is covered by UMP but not by Medicare, such as most prescription drugs. Medicare-enrolled UMP enrollees may still be required to pay coinsurance and deductible amounts when Medicare deductibles have not been met, or when a service is not covered by Medicare.

If a facility does not bill Medicare, coverage for services may not be available under UMP PPO if you are a Medicare-enrolled retiree. Call UMP Customer Service if you have questions regarding the status of your health care facility.

Coordination of benefits is managed in the same way for retirees as for active employees. When Medicare is primary, Medicare pays first and UMP PPO pays second. Here's how the reimbursement process works under UMP PPO's coordination of benefits:

- Medicare pays a portion of the bill. For all outpatient services in Alaska, Arizona, Colorado, Hawaii, Iowa, Nevada, North Dakota, Oregon, South Dakota, Washington, and Wyoming, the Part B Medicare administrator sends an electronic copy of each outpatient claim to UMP. You do not need to send a paper claim to UMP for your secondary benefit for those claims. For inpatient services, and for outpatient services in other states, Medicare sends you an Explanation of Medicare Benefits (EOMB) and you must send a copy of this to UMP.
- UMP identifies the difference between the Medicare allowed amount and the Medicare payment (the "remaining amount").
- UMP determines what your normal benefit would have been if UMP PPO had been your only payer.
- UMP pays the remaining amount or the normal UMP PPO benefit amount, whichever is less.

Here's an example to illustrate how this process works, assuming that your deductible has already been satisfied and you have received care in Washington from a network provider or anywhere in the U.S. from a provider who accepts Medicare assignment.

Provider's charge	**$300**
Medicare Benefit Calculation	
Medicare allowed charge:	$100
Medicare pays:	$80 (80% of $100)
Remaining amount:	$20
UMP PPO Benefit Calculation	
UMP PPO allowed charge:	$200
UMP PPO normal benefit:	$180 (90% of $200)
UMP PPO pays:	$20 ($20, the balance up to the Medicare allowed amount)
Enrollee Owes:	**$0**

In the example above, you owe nothing because the provider accepts Medicare assignment. This means the provider must write off the remaining amount of the bill that exceeds the Medicare allowed amount.

When the Primary Payer Is Other Than Medicare

When UMP PPO is secondary to another group health plan, standard coordination of benefits applies.

Here's how it works:

- Your primary payer pays a portion of the bill and sends you an Explanation of Benefits (EOB); you send a copy of the bill and the EOB to UMP PPO;
- UMP PPO reviews the primary plan benefit calculation, and the primary plan payment;
- UMP PPO determines what the normal benefit would have been if UMP PPO had been the only payer;
- UMP PPO compares allowed charges and determines which is the highest allowed charge; and
- UMP PPO pays the difference between the highest allowed charge and the primary plan's payment, up to the normal UMP PPO benefit amount.

Please contact UMP Customer Service at 1-800-352-3968 or 425-686-1350 in the Seattle area for assistance in answering any questions about benefits when you are covered by more than one plan.

Here's an example to illustrate the process and terms above. This example assumes that the primary plan ordinarily pays 80% of allowed charges after a $500 deductible.

Provider's charge	**$1,200**
Primary Plan Benefit Calculation	
Primary plan's allowed charge:	$1,000
Primary plan deductible:	$500
Primary plan pays:	$400 (80% of $500 balance)
UMP PPO Benefit Calculation	
UMP allowed charge:	$900
UMP PPO medical/surgical deductible:	$200
UMP PPO normal benefit:	$630 (90% of $700 balance)
Actual Payment by UMP PPO	
Highest allowed charge:	$1,000 (primary plan)
Primary plan's payment:	$400
UMP PPO pays:	***$600***

In the example above, you owe nothing unless this is a provider who has not agreed to accept the highest allowed charge as payment in full. If a provider is not contracted with UMP PPO or the primary plan as a network provider, you could be billed for the difference between the provider's actual billed charge ($1,200) and the highest of the plans' allowed charges ($1,000).

Coordination of Benefits (COB) Questionnaire

Please call UMP Customer Service to notify us of changes involving other coverage. You may receive a COB questionnaire from UMP. This provides UMP with information regarding other health care coverage. Failure to complete the form and return it to UMP may result in delay of claims payment. Please complete and return the form quickly.

When Another Party Is Responsible for Injury or Illness

How UMP Handles Payment

If you get injured or sick because of something someone else did, or didn't do, UMP covers benefits as it usually does. But if you get money back from someone else, you may have to repay UMP for expenses we covered for you. Even if you don't choose to file a claim against the responsible party, UMP can do so and you must help us by giving us whatever information we need.

For example, if you are hurt in a car accident and need medical treatment, UMP will pay for covered services. But if it turns out that either you or the other driver has auto insurance that should be covering your medical expenses, UMP can legally pursue getting money back from either or both of those insurance companies. In such a case, the auto insurance company generally has the first responsibility for those costs, not UMP. UMP pays so that you don't have to wait for auto insurance companies to settle legal questions, which can take some time.

When another party is responsible for your injury or illness, UMP has the right to share in the recovery of money paid on your behalf. This is called "subrogation."

Recovery of Expenses Initially Paid by UMP

If you file a lawsuit or other legal action against someone responsible for your injury or illness and get money back, UMP can ask for its share, up to the amount UMP paid on your behalf. You must give UMP information on any such action, including letting UMP know when you file a claim or lawsuit. You must also tell us about any proposed settlement with another party.

If you do file a lawsuit, you must include a claim for expenses UMP paid on your behalf, and allow UMP to participate in the lawsuit. As stated above, if you don't file to get money from the other party, UMP can still do so. You are required to cooperate in the process, and must not do anything to prevent UMP from recovering money owed to it.

UMP uses a company that specializes in this field to ask for information on your injury or illness and to follow up on third-party settlements. You must complete and return any requested forms to help UMP pursue its share of any money. If you are concerned about privacy and have a question about whether someone asking you for information on UMP's behalf is legitimate, please call UMP Customer Service at 1-800-352-3968.

Eligibility and Enrollment

Eligibility

(See "When Coverage Begins" to determine when coverage for eligible enrollees begins.)

Eligible Retirees

Retired or permanently disabled employees (referred to in this book as "retirees," "subscribers" or, in some cases, "enrollees") of state government, higher education, K-12 school districts, educational service districts, and employer groups are eligible for coverage by PEBB plans on a self-pay basis in accordance with Washington Administrative Code (WAC) 182-12-171 and WAC 182-12-211. A retired or permanently disabled employee under WAC 182-12-171 or WAC 182-12-211 is eligible for coverage by only one PEBB-sponsored medical plan even if eligibility criteria are met under two or more PEBB employers. A person enrolled in PEBB coverage as a subscriber cannot also be covered as a dependent on the PEBB plan of a spouse or other person. In order to be eligible, the following conditions must be met:

1. a. Under the following state of Washington retirement systems, individuals must immediately begin receiving a monthly retirement allowance, or have taken a lump-sum payment because their monthly benefit would be less than the minimum amount established by the Department of Retirement Systems:
    i. Public Employees Retirement System (PERS) 1, 2, or 3 (with the exception noted below in section 1.b.i.);
    ii. Teachers' Retirement System (TRS) 1, 2, or 3 (with the exception noted below in section 1.b.i.);
    iii. School Employees Retirement System (SERS) 2 or 3 (with the exception noted below in section 1.b.i);
    iv. Higher Education Retirement Plan (e.g., TIAA-CREF) (with the exception noted below in section 1.b.ii.);
    v. Law Enforcement Officers' and Fire Fighters' Retirement System (LEOFF) 1 or 2;
    vi. State Judges/Judicial Retirement System; or
    vii. Washington State Patrol Retirement System (WSPRS) 1 or 2.

   b. Individuals in the following state of Washington retirement systems are not required to begin receiving a monthly retirement allowance, but may instead meet these conditions:
    i. Public Employees Retirement System (PERS) 3, Teachers' Retirement System (TRS) 3, and School Employees Retirement System (SERS) 3 not receiving a monthly retirement allowance (defined benefit), must be at least age 55 with at least 10 years of service credit at the time of separation;
    ii. Higher Education Retirement Plan (e.g., TIAA-CREF), must be at least age 55 with at least 10 years of service, or at least age 62.

   c. Employees who are approved a disability retirement must apply for coverage within 60 days after the date of the approval notice from the Department of Retirement Systems or their higher-education retirement system.

   d. Appointed and elected officials of the legislative and executive branches of state government who leave public office may continue their PEBB medical coverage on a self-pay basis whether or not they receive a retirement benefit from a state retirement system, provided they apply no later than 60 days after the end of their term.

2. All eligible retirees must submit an election form to enroll or defer medical coverage **no later than 60 days** after their employer-paid or continuous COBRA coverage ends.

3. **Retirees and their covered dependents who are entitled to enroll in Medicare must enroll in Medicare Parts A and B**. A copy of their Medicare card must be provided to the PEBB program as proof of enrollment. Enrollees not entitled to either Medicare Part A or B must provide PEBB Benefit Services with a copy of the appropriate documentation from the Social Security Administration.

Deferring Coverage At or Following Retirement

If the retiree elects not to enroll in PEBB retiree coverage within 60 days after becoming eligible, or the retiree or his or her eligible surviving dependent(s) cancels their PEBB retiree coverage, the enrollee is not eligible for PEBB coverage unless he or she defers PEBB retiree coverage as outlined below.

Beginning January 1, 2001, a retiree may defer enrollment in PEBB medical coverage pursuant to WAC 182-12-205 if one of the following conditions is met. The retiree must be continually covered under another comprehensive, employer-sponsored medical plan as an employee or as the spouse or qualified same-sex domestic partner of an employee, or as a retiree or as the spouse or same-sex domestic partner on a retiree's retirement coverage from a federal retiree plan.

Pursuant to WAC 182-12-200, a retiree whose spouse is enrolled as an eligible employee in a PEBB or Washington State K-12 school district-sponsored health plan may defer enrollment in PEBB retiree medical plans and enroll in the spouse's PEBB or school district-sponsored health plan. If a retiree defers enrollment in a PEBB retiree medical plan, enrollment must also be deferred for dental coverage.

To defer medical and dental coverage, the retiree must submit a PEBB enrollment form to PEBB Benefit Services indicating his or her desire to defer coverage. This must be accomplished prior to the date coverage is deferred, or within 60 days after the date he or she is eligible to apply for PEBB-sponsored retiree benefits.

Eligible Dependents

Eligible subscribers may enroll dependents in their PEBB-sponsored medical plan if the dependent meets the criteria below. A dependent is eligible for coverage by only one PEBB-sponsored medical plan even if eligibility criteria are met under two or more plans. The following dependents are eligible:

1. The retiree's lawful spouse or same-sex domestic partner (qualified through the declaration certificate issued by PEBB).
2. The retiree's dependent children through age 19. The term "children" includes the retiree's biological children, stepchildren, legally adopted children, children for whom the retiree has assumed a legal obligation for total or partial support of a child in anticipation of adoption of the child, children of the retiree's qualified same-sex domestic partner, or children specified in a court order or divorce decree. Married children who qualify as dependents of the retiree under the Internal Revenue Code and additional legal dependents approved by the PEBB program are included. Dependent children who are registered students or who are developmentally or physically disabled are eligible beyond the age of 19 under the following conditions:
   a. Students ages 20 through age 23 are eligible if they are registered students at an accredited secondary school, college, university, vocational school, or school of nursing. Dependent student coverage begins the first day of the month in which the quarter or semester for which the dependent is registered begins and ends the last day of the month in which the student stops attending or in which the quarter or semester ends.

      To certify and recertify eligibility, the subscriber must submit a *Student Certification/Change* form to PEBB Benefit Services for review, along with proof that the dependent is a registered student. Acceptable proof may include: i) current quarter/semester registration from the institution; or ii) past year report card/transcript from the institution.

Misrepresentation or failure to notify PEBB Benefit Services of changes in status resulting in loss of eligibility, including changes in student status, may result in the subscriber being responsible for payment of services received. Coverage of dependent students continues year-round for those who attend three of the four school quarters or two semesters, and for three full calendar months following graduation as long as the retiree is covered at the same time, the dependent has not reached age 24, and the dependent meets all other eligibility requirements.

b. Dependent children of any age are eligible if they are incapable of self-support and are individuals with disabilities, developmental disabilities, mental illness, or mental retardation, provided that their condition occurred prior to age 20, or during the time they met the criteria for student coverage under PEBB rules. The subscriber must complete an application with proof that such disability occurred either (a) before the dependent became 20 years old; or (b) during the time the dependent met the criteria for student coverage as described above. The subscriber must submit the application to PEBB Benefit Services for approval by UMP. The PEBB program will, on behalf of UMP, request recertification of disability as frequently as necessary to verify the ongoing eligibility status of the dependent during the first two-year period following the child's attainment of the limiting age, and may request proof of disability annually thereafter.

3. Dependent parents covered under a PEBB medical plan before July 1, 1990, may continue enrollment on a self-pay basis as long as (a) the parent maintains continuous coverage in a PEBB-sponsored medical plan, (b) the parent continues to qualify under the Internal Revenue Code as a dependent of an eligible retiree, (c) the retiree who claimed the parent as a dependent continues enrollment in a PEBB plan, and (d) the parent is not covered by any other group medical insurance. Dependent parents may be enrolled in a different PEBB plan than that selected by the eligible retiree; however, dependent parents may not add additional family members to their coverage.

Verification of the dependency status of anyone enrolled under PEBB coverage may be requested at any time by the PEBB program or UMP.

Notify PEBB Benefit Services at 1-800-200-1004 as soon as possible of changes in student status. Such changes may result in your being required to pay for services received.

Medicare Entitlement

If an enrollee becomes entitled to Medicare, he or she should contact the nearest Social Security Office to inquire about Medicare enrollment.

Upon retirement, Medicare will become the primary coverage in most cases, and the PEBB-sponsored medical plan becomes secondary. PEBB plan enrollees retiring July 1, 1991, and after must be enrolled in Medicare Parts A and B, if entitled.

Please contact PEBB Benefit Services for information about retiree eligibility and benefit information.

Enrollment

Eligible retirees must submit an application to enroll in or defer PEBB coverage within 60 days from the date that their employment or continuous COBRA coverage ends.

Retirees who deferred PEBB medical coverage while enrolled in other comprehensive, employer-sponsored coverage may enroll in this plan within 60 days of the date other employer-sponsored coverage ends or during a PEBB open enrollment period. Proof of continuous enrollment in comprehensive, employer-sponsored coverage is required with the application. Contact PEBB Benefit Services for information on the premiums and coverage available.

Retirees who defer PEBB medical and dental coverage while enrolled as a retiree or dependent in a federal retiree plan will have a one-time opportunity to re-enroll in PEBB medical and dental coverage. To re-enroll in PEBB medical and dental coverage, retirees or their surviving dependents must submit

a *Retiree Enrollment/Change* form and proof of continuous enrollment in a federal retiree medical plan to PEBB Benefit Services either (a) during any PEBB open enrollment period; or (b) within 60 days after the date their other coverage ends.

An eligible subscriber may enroll dependents in his or her PEBB-sponsored medical plan if the dependent meets the criteria below. A dependent is eligible for coverage by only one PEBB-sponsored medical plan even if eligibility criteria are met under two or more plans.

Enrolling a Dependent Acquired After the Retiree's Effective Date of Coverage

Retirees may enroll dependents who become eligible after the retiree's effective date. Newly eligible dependents must be enrolled within 60 days after the date they become eligible.

1. Newborn or adoptive children must be enrolled within 60 days of eligibility if addition of the child increases the premium. When additional premium is not required, the retiree should notify PEBB Benefit Services of the birth, or the placement of the adoptive child, as soon as possible to ensure timely payment of claims.

   When a newborn or adoptive child becomes eligible before the 16th day of the month and the addition of the child increases the premium, the new full month's premium is charged; otherwise, the new premium will begin with the next full calendar month.

2. Dependents who lose other medical coverage must enroll within 60 days after the date their other coverage ends. Dependents will be required to provide proof of continuous medical coverage. If the dependent meets enrollment criteria and premiums are paid, coverage will begin the first day of the month following the date other coverage is terminated.

3. Eligible dependents may be added during any PEBB open enrollment period without proof of continuous coverage.

Contact PEBB Benefit Services for an enrollment/change form.

Special Enrollment Period for Dependents

Coverage for eligible dependents whose medical coverage was previously waived will be effective as described below.

1. Eligible dependents who were waived **while the retiree maintained enrollment in a PEBB medical plan** may be enrolled during any PEBB open enrollment period, or within 60 days of loss of other medical coverage. Outside of enrollment during a designated open enrollment, proof of other medical coverage is required to demonstrate that: 1) coverage was continuous; and 2) the period between loss of coverage and application for PEBB coverage is 60 days or less. Coverage for eligible dependents enrolling because of loss of other medical coverage will begin on the first day of the month following the date the prior coverage terminated. The enrollment form must be received by PEBB Benefit Services within 60 days after termination of other medical coverage. Coverage for eligible dependents enrolling during a PEBB open enrollment period will begin January 1 of the following year.

2. Retiree's marriage or qualified same-sex domestic partnership: Coverage for eligible dependents enrolling following a marriage or establishment of a qualified same-sex domestic partnership will begin on the first day of the month following the date of marriage or the date that the same-sex domestic partnership qualifies based on the declaration. If the date of marriage is the first calendar day of the month, coverage will begin on the date of marriage. The application for coverage must be received by PEBB Benefit Services within 60 days after the date of marriage or date that the same-sex domestic partnership qualifies based on the declaration.

3. Birth or adoption: Coverage for eligible dependents enrolling following a birth or placement of a child for adoption will begin on the first day of the month in which the birth or placement occurred. Coverage for a newborn child will begin at birth. Coverage for a child placed for adoption will begin on the date that

the retiree assumes a legal obligation for total or partial support in anticipation of adoption of the child. The application for coverage must be received by PEBB Benefit Services within 60 days of the birth or date of placement.

Disenrolling a Dependent

Retirees should contact PEBB Benefit Services to update their records. A retiree may delete a dependent by submitting an enrollment/change form to PEBB Benefit Services. Failure to notify PEBB of changes in status resulting in loss of eligibility may result in termination of coverage and the subscriber being responsible for payment of services received. Please refer to the "Options for Continuing Benefits" section for more information.

Enrollment changes must be submitted to PEBB Benefit Services within 60 days after the event that created the change.

Notify PEBB Benefit Services at 1-800-200-1004 of address, name, or other changes as soon as possible. This helps ensure that you receive important information about your UMP PPO benefits and helps us serve you better.

When Coverage Begins

Coverage for eligible retirees begins on the day following loss of other coverage provided application for retiree coverage is made in accordance with PEBB rules.

Coverage for eligible dependents begins on the day the retiree's coverage begins if the retiree lists the dependents on the enrollment form for coverage.

For newly acquired dependents (except newborn or adoptive children) who are enrolled in accordance with PEBB rules, coverage begins on the first day of the month following the date of acquisition/declaration. If the date of acquisition/declaration is the first day of a month, coverage will begin on the first day of the month of acquisition/declaration.

Coverage for a newborn child begins at birth. Coverage for an adoptive child begins on the date that the retiree assumes a legal obligation for total or partial support in anticipation of adoption of the child.

Coverage for other eligible dependents begins on the first of the month following the date the condition of dependency is established and approved by the PEBB program If the condition of dependency is established and approved on the first day of a month, coverage will begin on the date dependency is established.

Changing Medical Plans Mid-Year

Enrollees may change medical plans in the following situations:

1. During a PEBB open enrollment period.
2. If an enrollee changes residence during the plan year, he or she may change plan enrollment within 60 days of his or her move under the following conditions: if an enrollee moves from his or her plan's service area, he or she may enroll in any plan available in his or her new locality; or if a plan has not been available to the enrollee and he or she moves into that plan's service area, he or she may enroll in that plan. All such plan enrollment changes take effect on the first day of the month following the date the enrollee moves.
3. If a court order requires a retiree to provide medical coverage for an eligible spouse or child, the retiree may change medical plans and add the dependent immediately, with the change effective retroactive to the effective date of the court order or the retiree's effective date of coverage, whichever is later.
4. If an enrollee is covered under Medicare Part A and becomes enrolled in Medicare Part B, the enrollee may enroll in a Medicare Supplement Plan within six months of enrollment in Medicare Part B.
5. If an enrollee is covered under Medicare Part A and Medicare Part B and elects to enroll in Medicare Part D within the three-month period following the month in which the enrollee turns age 65, PEBB rules require the enrollee to make a plan change and select either Medicare Supplement Plan E or Plan J.
6. If a retiree's medical plan becomes unavailable, the retiree may choose another medical plan within 60 days after notification by

the PEBB program. Anyone who does not choose another medical plan within this time period will be enrolled in the medical carrier's successor plan if one is available, or will be enrolled in the Uniform Medical Plan PPO by default. Anyone defaulted to UMP PPO may not change medical plans until the next open enrollment.

7. If an enrollee incurs a claim that would meet or exceed a lifetime limit on all benefits.
8. If the enrollee exercises the special enrollment right to add newly acquired dependents due to marriage, qualification of a same-sex domestic partnership, birth, adoption, or placement for adoption. The enrollment application must be submitted to PEBB Benefit Services within 60 days after:
   - The marriage or qualification of same-sex domestic partnership; or
   - Birth, adoption, or placement for adoption of a child.
9. The enrollee's physician stops participation with the enrollee's medical plan and it is determined by the PEBB appeals manager that a continuity of care issue exists. Refer to WAC 182-08-198(2)(f) for specific details.

To change plans, the retiree must fill out a *Retiree Enrollment/Change* form. Retirees should contact PEBB Benefit Services to update their records.

Note: Your contractual relationship is with the health plan you have selected, not the individual providers available through the health plan. If an enrollee's provider or health care facility discontinues participation with UMP PPO, the enrollee may not change health plans until the next open enrollment period, except as provided in WAC 182-08-198(2)(f). UMP PPO cannot guarantee that any one physician, hospital, or other provider will be available and/or remain under contract with us.

When Coverage Ends

Coverage ends on the earliest of the following dates:

1. For any person enrolled in the plan, coverage ends on the date the plan terminates, if that should occur. Persons losing coverage will be given the opportunity to enroll in another PEBB plan.
2. If the retiree stops paying monthly premiums, coverage ends for the retiree and dependents on the last day of the month for which the last **full premium** was paid. A full month premium is charged for each calendar month of coverage. Premium payments are not prorated if an enrollee dies or terminates prior to the end of a month.
3. For a dependent who declines the opportunity or is ineligible to continue coverage on a self-pay basis, coverage ends at the end of the month in which he or she ceases to qualify as a dependent (such as a non-student child reaching age 20, or a spouse when a final decree of divorce is entered).

If an enrollee, or newborn eligible for benefits under "Obstetric and Newborn Care," is confined in a hospital or skilled nursing facility for which benefits are provided when PEBB coverage ends, and the enrollee is not immediately covered by other health care coverage, benefits will be extended until:

- The enrollee is discharged from the hospital or from a hospital to which the enrollee is directly transferred;
- The enrollee is discharged from a skilled nursing facility when directly transferred from a hospital and the skilled nursing facility confinement is in lieu of hospitalization;
- The enrollee is discharged from the skilled nursing facility or from a skilled nursing facility to which the enrollee is directly transferred;
- The enrollee is covered by another health plan that will provide benefits for the services; or
- Benefits are exhausted, whichever occurs first.

When coverage ends, the enrollee may be eligible for continuation of coverage or conversion to other health care coverage if application is made within the timelines explained in the following sections.

The enrollee is responsible for timely payment of premiums and reporting of changes in eligibility or address.

As a PEBB plan enrollee, it is the enrollee's responsibility to pay premiums when due. If the enrollee's account is delinquent, the enrollee's coverage will be terminated the end of the month in which the last full premium was received. If the enrollee's coverage is terminated due to delinquency, the enrollee's eligibility to participate in the PEBB program will end.

The enrollee and his or her covered dependent(s) or beneficiary are responsible for reporting changes within 60 days after the event, such as divorce, death, or when no longer a dependent as defined in WAC 182-12-260.

Failure to report changes can result in loss of premiums and loss of your or your dependents' right to continue coverage under the federal COBRA law or PEBB rules. If you need assistance in obtaining the proper form for communicating changes to the PEBB program, please call PEBB Benefit Services at 1-800-200-1004.

Options for Continuing PEBB Benefits

Some enrollees and their dependents covered by this plan who lose eligibility have options for continuing coverage: (1) PEBB rules allow for continued retiree coverage of dependents of a deceased subscriber, (2) the federal COBRA law gives enrollees the right to continue group coverage for a period of 18 to 36 months. Refer to the *Summary Plan Description of Continuation Coverage Rights Under COBRA and PEBB Rules* for specific details or call PEBB Benefit Services at 1-800-200-1004.

Retirees and their dependents also have the right of conversion to individual medical coverage when continuation of group medical coverage is no longer possible. The dependents of retirees also have options for continuing coverage for themselves following loss of eligibility.

Retirees and permanently disabled employees of employer groups whose participation in a PEBB plan ends may be eligible to continue PEBB coverage. Refer to the *Summary Plan Description of Continuation of Coverage Rights Under COBRA and PEBB Rules* for specific details or call PEBB Benefit Services at 1-800-200-1004.

Conversion of Coverage

Enrollees have the right to switch from PEBB group medical coverage (including COBRA) to an individual conversion plan offered by UMP when they are no longer able to continue PEBB group coverage, and are not entitled to Medicare or another group coverage that provides benefits for hospital or medical care. Enrollees must apply for conversion coverage within 31 days after their PEBB group coverage (including COBRA) ends.

Evidence of insurability is not required to obtain the conversion coverage. The rates, coverage, and eligibility requirements of our conversion plans differ from those of other UMP coverage. Enrollment in a conversion plan may limit your ability to later purchase an individual plan without going through health screening and/or a pre-existing condition waiting period. To obtain detailed information on conversion options offered by UMP, call PEBB Benefit Services at 1-800-200-1004.

UMP PPO As "Creditable Coverage" for Medicare Part D

Beginning January 1, 2006, Medicare will offer prescription drug coverage for people who have Medicare Parts A and/or B. This new plan is called Medicare Part D. If you have Medicare as your primary insurance, or will soon become eligible for Medicare, you should be aware that you cannot have both Medicare Part D and UMP retiree coverage.

There will be an "open enrollment" for Medicare Part D from November 15, 2005 through May 15, 2006. That means anyone who is currently on Medicare or eligible for Medicare during that time can enroll in Medicare Part D without paying a penalty. Individuals who register for Medicare Part D after May 15, 2006, will have to show proof that they had "creditable coverage" prior to applying for Part D or they will likely have to pay higher premiums—one percent higher for every month they went without creditable prescription drug coverage. Retirees becoming eligible for Medicare in future years will also face a premium penalty if they wait until after their initial eligibility period to sign up for Medicare Part D, and do not show proof that they have maintained "creditable coverage."

The Public Employees Benefits Board (PEBB) program has determined that UMP PPO's prescription drug coverage does qualify as creditable coverage for Medicare Part D. This means that if you decide in future years to drop your UMP PPO coverage and enroll in Medicare Part D, you will not have to pay a premium penalty for Part D.

Creditable coverage is defined by Medicare as being "at least as good" as Medicare Part D coverage. More specifically, creditable plans must pay out in benefits at least much as a Medicare Part D plan would (on average) and provide reasonable access to pharmacies and mail-order prescription drugs.

However, if you drop your UMP PPO coverage and sign up for Medicare Part D, you will need to select a Medicare Supplement Plan offered through PEBB to keep the option of returning to UMP PPO or other PEBB-sponsored health plans in the future. UMP PPO is not considered a Medicare Supplement Plan. If you do not sign up with a PEBB Medicare Supplement Plan or other PEBB-sponsored coverage, you won't be able to come back to a PEBB plan in the future.

Definitions

Allowed Charge(s)

The maximum amount UMP allows for a specific covered service or supply.

1. ***For professional services, durable medical equipment, supplies, and prostheses,*** allowed charges are the lesser of the provider's billed charge or:
   - For *network providers* (**within and outside of Washington**), the applicable contracted fee schedule amount.
   - For *non-network/out-of-network providers* **in Washington and the border counties of Oregon**, the UMP fee schedule amount.
   - For *non-network/out-of-network providers* **outside of Washington and the border counties of Oregon**, a regionally adjusted charge (defined on page 78-79).

   Note: The UMP fee schedule identifies certain services and procedures that are reimbursed on a case-specific (by report) basis. The allowed charge for those services or procedures may be based on UMP's fee schedule amounts for comparable services or procedures, billed charges (or percentage of billed charges), Medicare's fee schedules, rates negotiated by case managers, or other method(s) at UMP's discretion.
2. ***For network hospitals and other facilities,*** allowed charges for services are determined by the provider's contract with UMP, Beech Street, or Alternáre. For services from non-network or out-of-network facilities, allowed charges are generally based on the provider's billed charge, unless other arrangements have been made.
3. ***For prescription drugs,*** allowed charges are based on Express Scripts' standard reimbursement terms for its network pharmacies, unless other contractual arrangements or terms apply.

   When medications not normally self-administered are received in a provider's office, the UMP fee schedule amount is based on a percentage of the Average Wholesale Price (AWP) or a percentage of the Average Sales Price (ASP) determined by the Centers for Medicare and Medicaid Services.

UMP reserves the right to determine the amount payable for any service or supply.

Ambulatory Surgical Center (ASC)

A facility certified by Medicare or accredited by an accreditation organization recognized by the Centers of Medicare & Medicaid Services (such as the Joint Commission on Accreditation of Healthcare Organizations), that provides services for patients who receive invasive procedures requiring general, spinal, or other major anesthesia. (Examples of invasive procedures are certain biopsies, cardiac and vascular catheterizations, and endoscopies.) The ASC must be licensed by the state(s) in which it operates, unless that state does not require licensure.

Annual Medical/Surgical Deductible

A dollar amount you must pay each calendar year before UMP PPO pays medical/surgical benefits. Except for services specifically exempted in the "Summary of Benefits," the first $200 per individual in allowed charges for medical/surgical services (or $600 per family if three or more family members are enrolled on one subscriber's account) apply toward your annual medical/surgical deductible and are your responsibility.

Annual Medical/Surgical Out-of-Pocket Limit

The dollar limit on the amount you are required to pay each year in coinsurance and copayments for medical/surgical services (in addition to your annual medical/surgical deductible) is $1,500 per individual or $3,000 per family. Once you have reached this limit, most claims from network and out-of-network providers are paid at 100% of allowed charges, except as otherwise specified in this *Certificate of Coverage*. For additional information see page 6 of this document. The following services and charges are not counted towards your

or your family's annual medical/surgical out-of-pocket limit:

- Annual medical/surgical and prescription drug deductibles.
- Benefit reductions for failure to comply with medical review/preauthorization requirements.
- Charges beyond benefit maximums, limits, and allowed charges.
- Charges for expenses not covered.
- Copayments for emergency room care.
- Enrollee coinsurance/copayments for retail and our mail-service prescription drugs.
- Enrollee coinsurance/copayments for services from non-network providers.

For more information on how this works, see page 6 under "Your Cost-Sharing Requirements."

Annual Prescription Drug Deductible

A dollar amount you must pay each calendar year before UMP PPO pays prescription drug benefits. The first $100 per individual in allowed charges for prescription drugs (or $300 per family if three or more family members are enrolled on one subscriber's account) apply toward your annual prescription drug deductible and are your responsibility. For more information on how this works, see page 5 under "Your Cost-Sharing Requirements."

Appeal

See pages 54-55 under "What Is an Appeal?" for an explanation of appeals and how the process works.

Approved Provider Types (or Approved Provider)

See list on pages 15-17. A category of health care provider approved to deliver services under UMP PPO. Being an "approved" provider does not indicate the network status of a provider; an approved provider may be a network, out-of-network, or non-network provider. Some approved provider types, such as massage therapists, must be network providers to be covered by UMP PPO.

Brand Name Drug

A particular drug product sold under the proprietary name or trade name selected by the manufacturer.

Calendar Year

January 1 through December 31.

Chemical Dependency

An illness characterized by a physiological or psychological dependency on a controlled substance or alcohol.

Coinsurance

The percentage of allowed charges that UMP PPO pays for covered services. See also the definition of enrollee coinsurance (used to refer to the percentage you pay or "enrollee cost-share").

Coordination of Benefits

For enrollees covered by more than one health plan, the method used to determine which plan pays first, which pays second, etc., and the amount paid by each plan. Please see examples and description in "If You Have Other Medical Coverage" on pages 58-61.

Copayment

A flat dollar amount you pay when receiving specific services, treatments, or supplies, such as an inpatient hospitalization, emergency room care, or a prescription filled through our mail-service pharmacy.

Custodial Care

Care primarily to assist in activities of daily living, including institutional care primarily to support self-care and provide room and board. Custodial care includes, but is not limited to, help in walking, getting into and out of bed, bathing, dressing, feeding and preparing special diets, and supervising medications that are ordinarily self-administered. UMP PPO reserves the right to determine which services are custodial care.

Deductible

See definitions of "Annual Medical/Surgical Deductible" (page 71) and "Annual Prescription Drug Deductible" (page 72). For a description of how these work, see page 5 under "Your Cost-Sharing Requirements."

Dependent

A spouse, qualified same-sex domestic partner, child, or other family member of a UMP PPO subscriber (see "Eligible Dependents" on pages 64-65).

Domestic Partner

A qualified same-sex domestic partner is one who meets the requirements described on the *Declaration of Marriage or Same-Sex Domestic Partnership* form available from PEBB or your agency's personnel, payroll, or insurance office.

Durable Medical Equipment

Equipment that is:

- Designed for prolonged use;
- For a specific therapeutic purpose in treating your illness or injury;
- Medically necessary;
- Prescribed by the attending approved provider; and
- Primarily and customarily used only for a medical purpose.

Emergency

See Medical Emergency.

Enrollee

An employee, retiree, former employee, or dependent enrolled in UMP PPO.

Enrollee Coinsurance

The percentage you are required to pay on claims for which UMP PPO pays less than 100% of allowed charges.

Experimental or Investigational

A service or supply is experimental or investigational if any one or more of the following statements applies when the service is provided. The service or supply:

- Cannot be legally marketed in the United States without approval of the Food and Drug Administration (FDA), and that approval has not been granted;
- Is the subject of a current new drug or new device application on file with the FDA;
- Is provided as part of a Phase I or Phase II clinical trial, as the experimental or research arm of a Phase III clinical trial, or in any other manner intended to evaluate safety, toxicity, or efficacy;
- Is provided under a written protocol or other document that lists an evaluation of safety, toxicity, or efficacy among its objectives;
- Is under continued scientific testing and research concerning safety, toxicity, or efficacy;
- Is provided under informed consent documents that describe the service as experimental or investigational, or in other terms that indicate the service is being evaluated for safety, toxicity, or efficacy; or
- Is unsupported by prevailing opinion among medical experts (as expressed in peer-reviewed literature) as safe, effective, and appropriate for use outside the research setting.

In determining whether a service or supply is experimental or investigational, UMP relies exclusively on the following sources of information:

- The enrollee's medical records.
- Written protocol(s) or other document(s) under which the service is provided.
- Any consent document(s) the enrollee or enrollee's representative has executed, or will be asked to execute, to receive the service.
- Files and records of the Institutional Review Board (IRB) or similar body that approves or reviews research at the institution where the

service is provided, and other information concerning the authority or actions of the IRB or similar body.

- Up-to-date, published peer-reviewed medical literature (as defined on page 77) regarding the service, as applied to the enrollee's illness or injury.
- Regulations, records, applications, and any other documents or actions issued by, filed with, or taken by the U.S. Food and Drug Administration (FDA), Office of Technology Assessment, or other agencies within the U.S. Department of Health and Human Services, or any state agency performing similar functions.
- Information that your provider has shown proficiency in the procedure, based on experience and satisfactory outcomes in an acceptable number of cases.
- Expert opinion, at UMP's discretion.

Explanation of Benefits (EOB)

A detailed account of each claim processed by a medical plan, which is sent to you to notify you of claim payment or denial.

Family

All eligible family members (subscriber and dependents) enrolled in a single account.

Fee Schedule

UMP's maximum payment amounts for specific services or supplies. Network providers have agreed to accept these fees as payment in full for services to UMP PPO enrollees. See "Allowed Charge(s)" on page 71 for more details.

Formulary

See "Preferred Drug List" on page 78.

Generic Drug

A drug with the same active ingredient, but not necessarily the same inactive ingredients, as a brand-name drug that is no longer protected by a commercial patent.

Health Care Authority (HCA)

The Washington State agency that administers the following health care programs: Basic Health, Community Health Services, Prescription Drug Program, and Public Employees Benefits Board (PEBB). The HCA is also responsible for administering the Uniform Medical Plan Preferred Provider Organization and UMP Neighborhood, as medical plan options for PEBB enrollees.

Home Health Agency

An agency or organization that provides a program of home health care prescribed by an approved provider type (practicing within the scope of its license as an appropriate provider of home health services) and is Medicare-certified, accredited by the Joint Commission on Accreditation of Healthcare Organizations, or a UMP PPO network provider.

Hospice

Pain relief care and support services that address the physical, emotional, social, and economic needs of terminally ill patients and their families without intent to cure. Services may be provided in the home or in a hospice facility, and must be provided through a state-licensed hospice program.

Hospital

An institution accredited as a hospital under the Hospital Accreditation Program of the Joint Commission on Accreditation of Healthcare Organizations and licensed by the state where it's located. Any exception to this must be approved by UMP.

The term hospital ***does not*** include a convalescent nursing home or institution (or part) that:

- Furnishes primarily domiciliary or custodial care;
- Is operated as a school; or
- Is used principally as a convalescent facility, rest facility, nursing facility, or facility for the aged.

Limited Benefit

A benefit that is limited to a certain number of visits or a maximum dollar amount. Note that, for benefits limited to a certain number of visits, any visits that are applied to your annual medical/surgical deductible (see page 5) also count against your annual limit. For example, if your first 6 massage therapy sessions are applied to the deductible, you are entitled to a maximum of 10 more sessions for the rest of that calendar year, for a total of 16 visits (the maximum for massage therapy).

Maintenance Therapy

Medical services designed to preserve or retain a current level of activity or health. UMP reserves the right to determine which services constitute maintenance therapy.

Medical Emergency

The sudden and acute onset of a symptom or symptoms, including severe pain, that would lead a reasonable, prudent layperson to believe:

- A health condition exists requiring immediate medical attention; and
- Failure to provide medical attention would result in serious impairment to bodily functions or serious dysfunction of bodily organs, or would place the person's health in serious jeopardy.

UMP reserves the right to determine whether the symptoms indicate a medical emergency.

Medically Necessary Services, Supplies, or Interventions

UMP provides coverage for services, supplies, or interventions that are:

- Included as a covered service as described in the "Covered Expenses" section;
- Not excluded; and
- Medically necessary.

Except as provided under "Chemical Dependency Treatment" on page 26, a service is "medically necessary" if it is recommended by your treating provider and UMP's Medical Director or provider designee and if all of the following conditions are met:

1. The purpose of the service, supply, or intervention is to treat a medical condition;
2. It is the appropriate level of service, supply, or intervention considering the potential benefits and harm to the patient;
3. The level of service, supply, or intervention is known to be effective in improving health outcomes; and
4. The level of service, supply, or intervention recommended for this condition is cost-effective compared to alternative interventions, including no intervention.

For new interventions, effectiveness is determined by scientific evidence. For existing interventions, effectiveness is determined first by scientific evidence, then by professional standards, then by expert opinion. "Effective" means that the intervention, supply, or level of service can reasonably be expected to produce the intended results and to have expected benefits that outweigh potential harmful effects.

A health intervention is an item or service delivered or undertaken primarily to treat (i.e., prevent, diagnose, detect, treat, or palliate) a medical condition (i.e., disease, illness, injury, genetic or congenital defect, pregnancy, or a biological or psychological condition that lies outside the range of normal, age-appropriate human variation) or to maintain or restore functional ability. For purposes of this definition of "medical necessity," a health intervention is not considered separately from the medical condition and patient indications for which it is being applied.

An intervention, supply or level of service may be medically indicated yet not be a covered benefit or meet the standards of this definition of "medical necessity." UMP may choose to cover interventions, supplies, or services that do not meet this definition of "medical necessity"; however, UMP is not required to do so.

"Treating provider" means a health care provider who has personally evaluated the patient.

"Health outcomes" are results that affect health status as measured by the length or quality

(primarily as perceived by the patient) of a person's life.

An intervention is considered to be new if it is not yet in widespread use for the medical condition and patient indications being considered.

Scientific evidence consists primarily of controlled clinical trials that either directly or indirectly demonstrate the effect of the intervention on health outcomes. If controlled clinical trials are not available, observational studies that demonstrate a causal relationship between the intervention and health outcomes can be used. Partially controlled observational studies and uncontrolled clinical series may be suggestive, but do not by themselves demonstrate a causal relationship unless the magnitude of the effect observed exceeds anything that could be explained either by the natural history of the medical condition or potential experimental biases.

New interventions for which clinical trials have not been conducted because of epidemiological reasons (i.e., rare or new diseases or orphan populations) shall be evaluated on the basis of professional standards of care or expert opinion.

For existing interventions, the scientific evidence should be considered first and, to the greatest extent possible, should be the basis for determinations of medical necessity. If no scientific evidence is available, professional standards of care should be considered. If professional standards of care do not exist, or are outdated or contradictory, decisions about existing interventions should be based on expert opinion. Giving priority to scientific evidence does not mean that coverage of existing interventions should be denied in the absence of conclusive scientific evidence. Existing interventions can meet UMP's definition of medical necessity in the absence of scientific evidence if there is a strong conviction of effectiveness and benefit expressed through up-to-date and consistent professional standards of care, or, in the absence of such standards, convincing expert opinion.

A level of service, supply, or intervention is considered "cost effective" if the benefits and harms relative to costs represent an economically efficient use of resources for the patients with this condition. The application of this criterion to an individual case will be based on the characteristics of the individual patient. Cost-effective does not necessarily mean lowest price.

The fact a physician or other provider prescribes, orders, recommends, or approves a service or supply does not, in itself, make it medically necessary.

Preventive services not covered by the UMP PPO preventive care benefit will still be covered under the medical/surgical benefit if medically necessary.

UMP may require proof that services and supplies, including court-ordered care, are medically necessary. No UMP PPO benefits will be provided if that proof isn't received or isn't acceptable—or if UMP determines the service or supply is not medically necessary.

Medical/Surgical

Term applies to benefits and services that are not related to prescription drug coverage.

Network Provider(s)

Health care providers who have contracted with UMP (or are part of a group or provider network that has contracted with UMP, such as the Beech Street and Alternaré networks) to provide services to UMP enrollees at a reduced rate. When you use network providers, you cannot be billed for the difference between the provider's billed charge and the UMP allowed charge in most situations.

- **For services received in Washington and Idaho counties of Bonner, Kootenai, Latah, and Nez Perce**, UMP contracts directly with network providers (except for naturopathic physicians, acupuncturists, and massage therapists who contract through Alternáre, a division of American WholeHealth Networks).
- **For services elsewhere in the U.S.**, UMP PPO enrollees have access to network providers through the Beech Street network. If Medicare is your primary coverage, as long as you see a provider who accepts Medicare, UMP will reimburse the provider at the network rate, regardless of network affiliation.

Non-Network Provider(s)

Health care providers who practice within the service area of a network provider but are not contracted with UMP PPO or another UMP-contracted network (Alternáre or Beech Street). See page 15 for more information on how UMP pays non-network providers.

Nonpreferred Drug

A prescription drug designated nonpreferred in the *UMP Preferred Drug List* (see page 22) and covered under Tier 3.

Normal Benefit

The dollar amount of the benefit UMP PPO would normally pay if no other health plan had the primary responsibility to pay the claim.

Open Enrollment Period

A period defined by the HCA when you have the opportunity to change to another health plan offered by PEBB for an effective date beginning January 1 of the following year.

Out-of-Network Provider(s)

Health care providers located outside of the U.S. or in geographic areas where there is no access to a network provider, as determined by UMP.

Where there is no access to a network provider, UMP may pay a non-network provider at the "out-of-network" rate (80% of allowed charges). Non-network providers, even when reimbursed at the out-of-network rate, can bill you for charges that are more than UMP's allowed charge.

In the following cases, UMP may pay a non-network provider as out-of-network:

For primary care services	For specialist services
Urban: If no network provider is available within 30 miles* of the enrollee's residence. **Rural:** If no network provider is available within 50 miles* of the enrollee's residence.	**Urban and Rural:** If no network provider is available within 50 miles* of the enrollee's residence.

**Mileage refers to direct mileage as it appears on a map, not road mileage.*

Out-of-Pocket Limit

See definition of "Annual Out-of-Pocket Limit" on pages 71-72. For more information on how this works, see page 6 under "Your Cost-Sharing Requirements."

Over-the-Counter Drugs

Medications that can be obtained without a prescription.

Over-the-Counter Equivalent

An over-the-counter drug or product with identical active ingredients and strength as a prescription drug or product in a comparable dosage form.

Partial Hospitalization

Ambulatory services provided in a hospital setting which permit the patient to return to his or her residence at night.

PEBB Plan

One of several health insurance plans, including the state's own self-funded preferred provider plans, Uniform Medical Plan Preferred Provider Organization and UMP Neighborhood, offered through the Public Employees Benefits Board (PEBB) program to public employees, former employees, retirees, and their dependents. Benefits and eligibility are designed by the PEBB and administered by the Health Care Authority (HCA) as part of a comprehensive employee/retiree benefits package.

Peer-Reviewed Medical Literature

Scientific studies printed in journals or other publications where original manuscripts are published only after being critically reviewed for scientific accuracy, validity, and reliability by unbiased independent experts. Peer-reviewed medical literature, for example, does not include information from health-related Web sites or in-house publications of pharmaceutical manufacturers.

Plan-Designated Facility

A facility, such as a hospital that UMP designates for the performance of a particular service(s) for an enrollee. Some services are covered only if the

designated facility is used. Such a designation will be made by UMP Medical Review, Case Manager, or the UMP Medical Director.

Preauthorization

Approval by UMP PPO for certain services before they are provided to the enrollee. Preauthorization is not a guarantee of coverage. Failure to preauthorize certain medical services or drugs could result in denial of the claim. Please see "Preauthorizing Services" starting on page 18 for medical/surgical services that require preauthorization, and "Limits on Drug Coverage" on page 24 for information on drugs that require preauthorization.

Preferred Drug

A prescription drug that is listed on the *UMP Preferred Drug List* (see page 22) and covered under either Tier 2 (for preferred brand-name prescription drugs) or Tier 1 (for generic drugs).

Preferred Drug List

A list of selected prescription medicines that are covered by UMP. Covered drugs on the list are designated by "tiers": Tier 1 drugs are generic drugs, Tier 2 are preferred brand-name drugs, and Tier 3 drugs are nonpreferred. The *UMP Preferred Drug List* is based on a combination of the Washington Preferred Drug List and the Express Scripts National Formulary.

Prenatal

During pregnancy.

Preventive Services

Under UMP PPO, only certain services recommended in U.S. Preventive Services Task Force guidelines are covered under the "Preventive Care" benefit; see lists on pages 39-43 for specific services covered.

Primary Care Services

Medical care from nonspecialist providers including general practitioners, family practitioners, pediatricians, and internists.

Primary Payer

The insurance plan required to process the claim first for all expenses allowed under its coverage when an enrollee is covered by more than one group insurance plan.

Professional Services

Non-facility medical/surgical services performed by professional providers such as medical doctors, doctors of osteopathy, naturopathic physicians, and advanced registered nurse practitioners.

Proof of Continuous Coverage

The Certificate of Creditable Coverage provided to the enrollee by the enrollee's prior health plan; or a letter from the enrollee's employer, on the employer's letterhead, providing the time period the enrollee and/or his or her dependent(s) were covered by health insurance.

Provider

An individual medical professional, hospital, skilled nursing facility, other facility or organization, pharmacy, program, equipment and supply vendor, or other entity that provides care or bills for health care services or products.

Provider Network(s)

A list of providers who are contracted to provide health care services to enrollees. These providers have agreed to see UMP enrollees under certain rules, including billing at reduced rates (see "Allowed Charge(s)" on page 71). UMP maintains its own provider network, contracting with Alternaré for naturopaths, acupuncturists, and massage therapists, and with the Beech Street network for services outside of Washington State.

Regionally Adjusted Charge

The maximum payment for a specific service or supply allowed under UMP fee schedules, when performed by out-of-network providers and non-network providers outside of Washington State and Oregon border counties. UMP will establish regionally adjusted charges for each geographic area and service using one of the following:

- Medicare's allowable charge in the geographic region, which may be increased by a percentage determined by UMP;
- Charges most frequently made by providers with similar professional qualifications for comparable services in the provider's geographic area

(based on the 75th percentile of charge data collected by Ingenix, an organization that maintains the Prevailing Healthcare Charges System);

- Most consistent charge made by an individual provider for a particular service;
- The provider's actual charge after any discounts or reductions; or
- The UMP, Beech Street, or Alternáre fee schedule.

UMP reserves the right to determine the amount payable for any service or supply.

Reimbursement Level

How much UMP pays for a particular service or provider type (see pages 14-15 under "How the UMP PPO Works" for specific details). For example, the network provider "reimbursement level" is usually 90% of the allowed charge.

Respite Care

Continuous care for a homebound hospice patient of more than four hours a day to provide family members temporary relief from caring for the patient.

Secondary Coverage

When you are covered by more than one health plan, you have "secondary coverage" that may pay part or all the rest of the bill from the provider after your primary payer has paid (see page 78). See "If You Have Other Medical Coverage" on pages 5-61 for details.

Skilled Nursing Facility

An institution, or part of an institution, that provides skilled nursing care 24 hours a day and is classified as a skilled nursing facility by Medicare. Medicaid-eligible, long-term care facilities are not necessarily skilled nursing facilities.

Standard Reference Compendium

Refers to any of these sources:

- The American Hospital Formulary Service Drug Information.
- The American Medical Association Drug Evaluation.
- The United States Pharmacopoeia Drug Information.
- Other authoritative compendia as identified from time to time by the federal Secretary of Health and Human Services.

Subscriber

The individual or family member who is the primary certificate holder and UMP PPO enrollee.

Substance Abuse Treatment Facility

An institution (or section) specifically engaged in rehabilitation for alcoholism or drug addiction that meets all of these criteria:

- Is licensed by the state;
- Keeps adequate patient records that contain course of treatment, progress, discharge summary, and follow-up programs;
- Provides services, for a fee, to persons receiving alcoholism or drug addiction treatment including room and board as well as 24-hour nursing; and
- Performs the services under full-time supervision of a physician or registered nurse.

Tier

A term that tells you how much you will have to pay for a covered prescription drug. UMP's prescription drug benefit categorizes covered medications into three tiers. See page 23 for details on the prescription drug tiers.

Tobacco Cessation Services

Services provided for the purpose of quitting tobacco use, usually cigarette smoking. Only the *Free & Clear* program is covered by UMP (see page 45 for details). When recommended by *Free & Clear* counselors, nicotine replacements and other drugs prescribed are also covered at no cost to the enrollee. *Free & Clear* is offered ***at no charge*** to enrollees, and there is no limit to how many times you may enroll.